

Parent Consent and Authorized Health Care Provider Authorization For Management of Diabetes at School and School Sponsored Events

Individualized School Healthcare Plan (ISHP) and Procedures will provide details for Implementation
(ATTACH "ALGORITHMS FOR BLOOD GLUCOSE RESULTS")

Pupil: _____	DOB: _____	School: _____	Grade: _____
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Authorized Health Care Provider's Written Authorization: Please initial and check all boxes that apply

<p>1. Blood Glucose Testing</p> <input type="checkbox"/> Before am snack <input type="checkbox"/> Before lunch <input type="checkbox"/> 2 hours after lunch <input type="checkbox"/> 2 hours after a correction dose <input type="checkbox"/> For suspected hypoglycemia <input type="checkbox"/> At student's discretion excluding suspected hypoglycemia <input type="checkbox"/> Only at student's discretion <input type="checkbox"/> No blood glucose testing at school Target range for blood glucose at school _____ <p>2. Hypoglycemia* - blood glucose less than 70</p> <input type="checkbox"/> Self treatment of mild lows <input type="checkbox"/> Assistance for all lows <input type="checkbox"/> Provide extra protein & carb snack after treating lows or feed snack/meal early (if scheduled within the hour) <input type="checkbox"/> OK to use glucose gel inside check; even if unconscious <input type="checkbox"/> Glucagon injection IM (for severe hypoglycemia): <u> </u> 0.5 mgm <u> </u> 1 mgm <p>3. Hyperglycemia*</p> <input type="checkbox"/> If blood glucose > _____ initiate insulin administration order <input type="checkbox"/> If blood glucose > _____ or exhibit symptoms of ketosis, check ketones <input type="checkbox"/> Check urine ketones <input type="checkbox"/> Check blood ketones <p>4. Meal Plan</p> Snacks/meals: <input type="checkbox"/> Mandatory <input type="checkbox"/> At student's discretion <input type="checkbox"/> AM snack time: _____ PM snack time: _____ <input type="checkbox"/> Lunch time: _____ Other: _____ <input type="checkbox"/> Extra food allowed: <input type="checkbox"/> Parent's discretion <input type="checkbox"/> Student's discretion <p>5. Exercise (Check and/or complete all that apply): Liquids and solid carb sources must be available before, during and after all exercise. No exercise if most recent blood glucose is <70 <input type="checkbox"/> Eat _____ gms CHO for vigorous exercise: <input type="checkbox"/> Before, <input type="checkbox"/> Every 30 minutes during, <input type="checkbox"/> After <input type="checkbox"/> No exercise when blood glucose is > _____ or ketones are present</p> <p>6. Authorized Health Care Provider Verification: Student can self-perform the following procedures (parent and school nurse must verify competency as well): <input type="checkbox"/> Blood glucose testing <input type="checkbox"/> Measuring insulin <input type="checkbox"/> Injecting insulin <input type="checkbox"/> Determining insulin dose <input type="checkbox"/> Independently operate insulin pump <input type="checkbox"/> Other _____</p> <p>*(Refer to attached "Algorithms for Blood Glucose Results" for summary of treatment procedures)</p>	<p>7. Insulin Orders (complete only if insulin is needed at school): Brand name and type: _____ Administration times (fill in times for only those that apply): <input type="checkbox"/> Breakfast <input type="checkbox"/> AM snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM snack <input type="checkbox"/> Other: _____ Insulin administration via: <input type="checkbox"/> Syringe and vial <input type="checkbox"/> Insulin pump <input type="checkbox"/> Insulin pen <input type="checkbox"/> Other: _____ Insulin dose determined by (Check all that apply): Food/bolus doses: <input type="checkbox"/> Standard lunchtime dose: _____ <input type="checkbox"/> Insulin to carbohydrate ratio: _____ # unit(s) insulin per _____ gms Carbohydrate <input type="checkbox"/> Correction Calculation (complete only those that apply) • Give _____ unit(s) for every _____ mg/dl above _____ mg/dl • Decrease correction by _____ % unit(s) if PE or increased activity is anticipated after correction dose, or last dose was given less than 2 hours before.</p> <p>OR</p> <input type="checkbox"/> Written sliding scale as follows: Blood Glucose from _____ to _____ = _____ Units Blood Glucose from _____ to _____ = _____ Units Blood Glucose from _____ to _____ = _____ Units Blood Glucose from _____ to _____ = _____ Units <p><input type="checkbox"/> Add carb calculation insulin dose and correction calculation for total insulin dose/bolus</p> <p>8. Bus Transportation: <input type="checkbox"/> Blood glucose test not required prior to boarding bus <input type="checkbox"/> Test blood glucose 10 to 20 minutes before boarding bus • Provide 15 gm glucose source if blood glucose is < _____ mg/dl • Provide care as follows: _____ Other: _____</p>
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Other Needs: Specify on Authorized Health Care Provider stationary or prescription pad and attach.

Authorized Health Care Provider Authorization for Management of Diabetes at School

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical health care services may be performed by uncensored designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

Authorized Health Care Provider Name: _____ **Signature** _____ **Date** _____ **Phone** _____

Address _____ **City** _____ **Zip** _____

I have instructed _____ (Child's Name) in the proper way to use his/her medications. It is my professional opinion that _____ (Child's Name) should be allowed to carry and use that medication by him/herself. _____ **Authorized Healthcare Provider Initial**

I request that the School Nurse provide me with a copy of the completed Individualized School Healthcare Plan (ISHP).

Parent Consent for Management of Diabetes at School

I(We), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the following for Management of Diabetes in school be administered to our (my) child in accordance with state laws and regulations.

- I will:
1. Provide the necessary supplies and equipment
 2. Notify the school nurse if there is a change in pupil health status or attending Authorized Health Care Provider
 3. Notify the school nurse immediately and provide new consent for any changes in doctor's orders.

I authorize the school nurse to communicate with the Authorized Health Care Provider when necessary. I understand that I will be provided a copy of my child's completed Individual School Healthcare Plan. (ISHP)

Parent/Guardian Signature _____ Date _____

_____ Date _____

Reviewed by School Nurse (Signature) _____ **Date** _____

Reviewed by Principal (Signature) _____ **Date** _____