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

Pupil: **DOB:** **ID#:** **School:** **Grade:**

Authorized Health Care Provider's Written Authorization: Please initial and check *ALL* boxes that apply

1. Blood Glucose Testing

- ☐ Before am snack ☐ Before Lunch ☐ 2 hours after lunch
- ☐ 2 hours after a correction dose ☐ For suspected hypoglycemia
- ☐ At student's discretion excluding suspected hypoglycemia
- ☐ Only at student's discretion ☐ No blood glucose testing at school

Target range for blood glucose at school _____

2. Hypoglycemia - blood glucose less than 70

- ☐ Self Treatment of mild lows ☐ Assistance for all lows
- ☐ Provide extra protein & carb snack after treating lows or feed snack/meal early (if scheduled within the hour)
- ☐ O.K. to use glucose gel inside cheek
- ☐ Glucagon injection IM (for severe hypoglycemia):___0.5 mgm___1mgm
- ☐ Typical Symptoms: _____

3. Hyperglycemia

- ☐ If blood glucose > _____ initiate insulin administration order
- ☐ If blood glucose > _____ or exhibit symptoms of ketosis, check ketones
- ☐ Check urine ketones ☐ Check blood ketones
- ☐ Typical Symptoms: _____

4. Meal Plan

Snacks/meals: ☐ Mandatory ☐ At student's discretion

- ☐ AM snack time: _____ PM snack time: _____
- ☐ Lunch time: _____ Other: _____
- ☐ Extra food allowed: ☐ Parent's discretion ☐ Student's discretion

5. Exercise (Check and/or complete all that apply):

Liquid and solid carb sources must be available before, during and after all exercise.

No exercise if most recent blood glucose is <70

- ☐ Eat _____gms CHO for vigorous exercise:
- ☐ Before, ☐ Every 30 minutes during, ☐ After
- ☐ No exercise when blood glucose is > _____ or ketones are present

6. Authorized Health Care Provider Verification:

Student can self-perform the following procedures (parent and school nurse must verify competency as well)

- ☐ Blood glucose testing ☐ Measuring insulin ☐ Injecting insulin
- ☐ Determining insulin dose ☐ Independently operating insulin pump
- ☐ Other: _____

7. Insulin Orders *(complete only if insulin is needed at school):*

Brand name and type: _____

Administration times (fill in times only for those that apply):

- ☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack
- ☐ Other: _____

Insulin administration via:

- ☐ Syringe and vial ☐ Insulin pump ☐ Insulin pen
- ☐ Other: _____

Insulin dose determined by (check all that apply):

Food/bolus doses:

- ☐ Standard lunchtime dose: _____
- ☐ Insulin to carbohydrate ratio:

_____# unit(s) insulin per _____gms Carbohydrate

A. ☐ Correction Calculation (complete only those that apply)

- Give _____unit(s) for every _____mg/dl above _____mg/d
- 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.

OR

B. ☐ 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
Blood Glucose from _____ to _____= _____Units
Blood Glucose from _____ to _____= _____Units
Blood Glucose from _____ to _____= _____Units

☐ **Add carb calculation, insulin dose, and correction calculation for total insulin dose/bolus (for parent use)**

8. Bus Transportation:

- ☐ Blood glucose test not required prior to boarding bus
- ☐ 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: _____

_____

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 unlicensed 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 (print name) **Signature** **Date** **Phone**

Address **City** **Zip**

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

☐ **Other Needs: Specify on Authorized Health Care Provider stationery or prescription pad and attach.**

Provider Office Stamp

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 California Education Code 49423.5.

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.

Parent/Guardian Signature _____ Date _____

Address _____ Phone Number _____

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