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:**

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)
☐OK to use glucose gel inside check; even if unconscious
☐Glucagon injection IM (for severe hypoglycemia): __0.5 mgm
__1 mgm

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

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 operate insulin pump
☐Other _____

***(Refer to attached "Algorithms for Blood Glucose Results" for summary of treatment procedures)**

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):
☐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
☐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.

OR
☐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

☐**Add carb calculation insulin dose and correction calculation for total insulin dose/bolus**

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: _____

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 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 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 byPrincipal (Signature)_____ **Date** _____