

**Parent Consent and Authorized Health Care Provider Authorization For Management of Diabetes
at School and School Sponsored Events (Attach Algorithms for Blood Glucose Results form)**

Student's Name _____ **School/Grade** _____ **DOB** _____

1. Blood Glucose Testing:

- Before AM snack Before Lunch 2 hours after lunch 2 hours after 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, Refer to Algorithm for Blood Glucose Results form:

- Self-treatment of mild lows Assistance for all lows OK to use glucose gel inside cheek
- Provide extra protein & carb snack after treating lows or feed snack/meal early (if scheduled with the hour)
- Glucagon injection IM (if unconscious, CALL 911): _____ 0.5mgm _____ 1 mgm Glucose Tablets

3. Meal Plan, Parent/Guardian must provide all supplies and snacks:

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

4. 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
- Food/Carb before exercise Every 30 minutes during Food/Carb after exercise

5. Authorized Health Care Provider Verification: Student can self-perform the following procedures: (Parent/Guardian(s) and School Nurse must verify competency as well)

- Blood glucose testing Measuring insulin Injecting insulin Independently operate insulin pump
- Other: _____

6. Insulin Orders (complete only if insulin in needed at school) Brand name and type: _____

Administration times (fill in times for only those that apply): Breakfast AM snack Lunch PM snack
 Insulin administration via: Syringe and vial Insulin pump Insulin pen

Insulin dose determined by (check all that apply):

- Pupil independently
- Pupil with parent or school designee (using sliding scale when parent not available)
- Parent designee (all parent designees are trained by the parent and are not employees of the School District)

Correction Calculation (complete only those that apply)

- Insulin to carbohydrate ratio: _____ # unit(s) insulin per _____ gms Carbohydrate (determined by parent or student independently)
- 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 does 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

7. Glucose testing at end of school day:

- Blood glucose test not required prior to leaving campus Test blood glucose 10 to 20 minutes before leaving campus
- For hypoglycemia, refer to attached Algorithm form For hyperglycemia, refer to attached Algorithm form

8. Parent responsible for coordinating care for all after school activities.

9. Other Needs: Specify on Authorized Health Care Provider stationary or prescription pad and attach.

PLEASE FILL OUT REVERSE SIDE → → →

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/Clinic Stamp: _____

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. _____ (Dr's Initials)

Parent Consent of Management of Diabetes at School

I (We) , the understated, 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.

Parent/Guardian Signatures:1) _____ Daytime phone: _____ Date: _____

2) _____ Daytime phone: _____ Date: _____

For School Use

Reviewed by District Nurse (Signature): _____ Date: _____

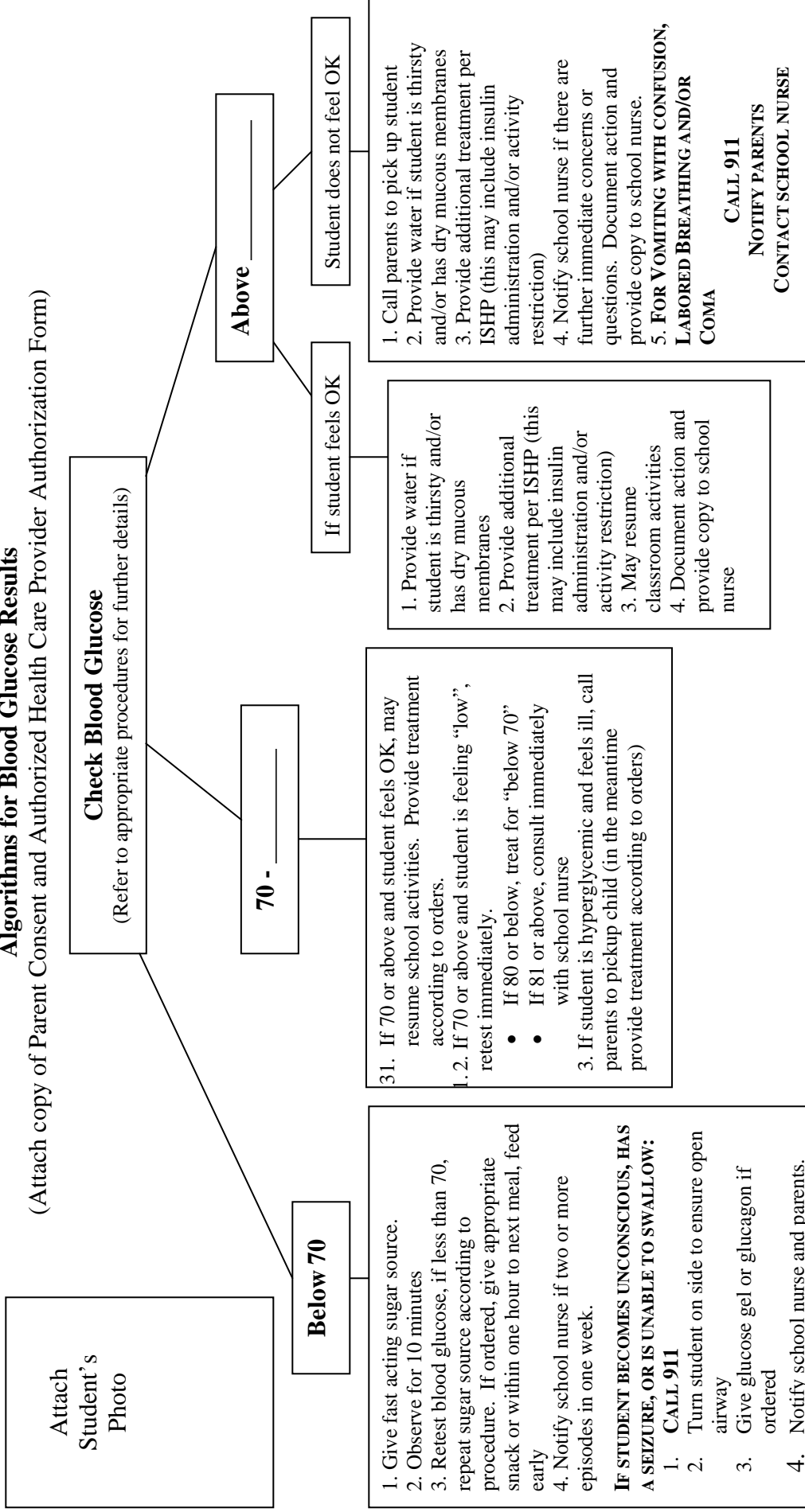
Reviewed by School Health Tech (Signature): _____ Date: _____

Reviewed by School Principal (Signature): _____ Date: _____

PLEASE FILL OUT REVERSE SIDE → → →

Algorithms for Blood Glucose Results

(Attach copy of Parent Consent and Authorized Health Care Provider Authorization Form)



Student's Name:	DOB:	
School:	Grade:	School Fax:
Parent/Guardian(s) Signature 1.)	2.)	
Home Phone:	Daytime:	Other:
Physician's Signature:	Print Name:	
Physician's Phone:	Fax:	
Clinic Name/Address:		

- Fast Acting Sugar Sources:**
- 15 gm glucose tablets
 - 15 gm glucose gel
 - 1/3 c. sugared soda
 - 1/2 c. orange juice
 - 1/2 c. apple juice
 - 1/2 c. grape juice
 - 1 tube cakemake gel (19 cm)
 - 3 ten sugar (in water)