

**Santa Maria Joint Union High School District
Parent Consent and Healthcare Provider Authorization
For Management of Diabetes at School and School Sponsored Events**

Student: _____ D.O.B. _____ School: _____ Grade: _____

Authorized Healthcare Provider's Written Authorization
Healthcare Provider: Please fill in lines and check all boxes that apply

1. Blood Glucose Testing

- before a.m. 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. Mild Hypoglycemia* (BG < 70 mg/dl or BG < _____ mg/dl)

Student must never be alone when hypoglycemia is suspected and should be treated on site
 Give 15 gm OR give _____ gm fast-acting glucose and recheck in 15 minutes OR minutes. If still hypoglycemic, treat again with same dose of glucose and recheck at same interval until normal.
 Notify parent if not improved after 3 treatments.
 Provide extra protein and carb snack after treating lows if next meal/snack not scheduled for 1 hr 2 hrs
 Call parent for symptoms of hypoglycemia, but BG is normal.

3. Severe Hypoglycemia (seizure, unconscious, combative, unable to swallow)

- Call 9-1-1; ensure open airway
- OK to use glucose gel inside cheek if conscious
- Glucagon injection IM 0.5 mg 1 mg, if seizure or unconscious

4. Hyperglycemia (Intervention if BG greater than _____ mg/dl)

If thirsty or looks dry, provide water. If student is ill or vomiting, call parent. For confusion, labored breathing or coma--call 9-1-1
 Call parent if BG > _____ mg/dl, or if ketones _____ or larger.
 If BG > _____ mg/dl initiate insulin administration orders
 If BG > _____ mg/dl, check ketones in urine blood
 Return to class if asymptomatic or doesn't meet above criteria.

5. Meal Plan

Meal/snack will be considered mandatory unless student's discretion also checked. Attach orders for breakfast or PM snacks if needed. Timing will be routine school times unless indicated. Content of meal/snack to be specified by:
 parent student healthcare provider (attach if needed)
 AM snack: at student's discretion special time: _____
 Lunch: at student's discretion special time: _____

6. Exercise (complete only if needed):

Liquid/solid carb sources must be available for all exercise.
 Follow hypoglycemia, illness, and hyperglycemia protocols when relevant.
 Eat _____ extra grams of carbs for vigorous exercise:
 before, every 30 minutes during, after exercise
 Student may disconnect pump for up to _____ hour(s) or decrease basal rate at their discretion.

7. 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"/> No | <input type="checkbox"/> Yes, supervised | <input type="checkbox"/> Yes, unsupervised |
| <input type="checkbox"/> Measuring insulin | <input type="checkbox"/> No | <input type="checkbox"/> Yes, supervised | <input type="checkbox"/> Yes, unsupervised |
| <input type="checkbox"/> Injecting insulin | <input type="checkbox"/> No | <input type="checkbox"/> Yes, supervised | <input type="checkbox"/> Yes, unsupervised |
| <input type="checkbox"/> Determining insulin dose | <input type="checkbox"/> No | <input type="checkbox"/> Yes, supervised | <input type="checkbox"/> Yes, unsupervised |
| <input type="checkbox"/> Independently operate insulin pump | <input type="checkbox"/> No | <input type="checkbox"/> Yes, supervised | <input type="checkbox"/> Yes, unsupervised |
| <input type="checkbox"/> Other _____ | | | |

(May attach "Algorithms for Blood Glucose Results" for summary of treatment procedures)

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

Brand name of insulin: _____
Routine administration times (fill in times for all those that apply):
___ Breakfast ___ AM Snack ___ Lunch ___ Other: _____
Insulin Administration via:
___ syringe ___ pump ___ pen ___ other: _____
Insulin dose determined by (Check all that apply):
Food/bolus insulin dose (complete only those that apply):
___ insulin to carb ratio: ___ unit(s) insulin per ___ gm carbohydrate or
___ routine breakfast dose ___ unit(s) (if given at school)
___ routine AM snack dose ___ unit(s)
___ routine lunch dose ___ unit(s)
___ routine other dose ___ unit(s) (time of this dose: _____)
Correction Dose (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.
___ Sliding scale as follows:
Blood Glucose from ___ to ___ = ___ Units
Blood Glucose from ___ to ___ = ___ Units
Blood Glucose from ___ to ___ = ___ Units
Blood Glucose from ___ to ___ = ___ Units
___ **OK to add food/bolus dose to correction dose**

9. 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 Needs: Specify on Authorized Healthcare 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:

Signature _____ **Date** _____
Phone _____ **FAX** _____

Stamp Physician Name/Address Below:

___ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that he/she be allowed to carry and use that medication by him/herself.
(Child's name)

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

Consentimiento de los padres' para la gestión de la Diabetes en la escuela

Yo , los abajo firmantes, los padres o representante de la pupila con nombre anterior, solicitar que las anteriores órdenes escritas para la gestión de la Diabetes en la escuela administrarse a mi (nuestro) hijo de conformidad con las leyes y reglamentos.

- Yo: 1. Proporcionar los suministros necesarios y equipo
2. Notificar a la enfermera de la escuela, si hay un cambio en el estado de salud del alumno o asistir a proveedor de atención de la salud autorizado
3. Notificar a la escuela enfermera inmediatamente y proporciona nueva consentimiento para cualquier cambio en las órdenes del médico, Autorizo a la enfermera de la escuela para comunicarse con el proveedor de cuidado de la salud autorizado cuando sea necesario. Entiendo que yo le proporcionaré que una copia de mi hijo completó el Plan Individual de salud escolar. (ISHP)

Padre o tutor firma _____ Nombre con letra de molde _____ Fecha _____

Iniciales:

___ **Autorizo a que la enfermera de la escuela se comunice con el doctor cuando sea necesario.**
___ **Solicito una copia del Plan Individual de Cuidado Médico completo de la enfermera de la escuela.**
___ **Por medio de la presenta autorizo que la enfermera de el Plan Individual de Cuidado Médico a los maestros de mi estudiante, personal médico.**

Autoadministracion:

___ Yo solicitar que mi hijo pueda llevar / auto administrar su medicación.
___ Yo solicitar que mi hijo se permitió a prueba de la glucosa en la sangre y per forma solo

Estoy de acuerdo a y queda eximir del distrito y sus funcionarios, agentes, empleados y voluntarios para cualquier reclamo, demanda, causa de acciones, responsabilidad, daños, gastos o pérdidas de cualquier tipo, incluyendo lesiones corporales o muerte, debido a o de actos de omisiones con respecto a la administración de la medicación.

Padre o tutor firma _____ Nombre con letra de molde _____ Fecha _____