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.** **Grade:** **School Year:**

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):

___ Blood glucose testing	☐ No	☐ Yes, supervised	☐ Yes, unsupervised
___ Measuring insulin	☐ No	☐ Yes, supervised	☐ Yes, unsupervised
___ Injecting insulin	☐ No	☐ Yes, supervised	☐ Yes, unsupervised
___ Determining insulin dose	☐ No	☐ Yes, supervised	☐ Yes, unsupervised
___ Independently operate insulin pump	☐ No	☐ Yes, supervised	☐ Yes, unsupervised
___ 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:

Stamp Physician Name/Address Below:

Signature ___________________________________ **Date** _______________

Phone __________________________ **FAX** ___________________________

___ I have instructed _______________________ (Child's name) 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/her.

_____ 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, the parent/guardian of the above named pupil, request that the above written orders for Management of Diabetes in school be administered to 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,

Parent/Guardian Signature _________________________________ Print Name: ____________________________ Date __________

Initial:

________I authorize the school nurse to communicate with the physician when necessary.

________I request a copy of the completed Individualized Healthcare Plan from the School Nurse

________I hereby authorize the School Nurse to release the completed Individualized Healthcare Plan to my student's instructors, healthcare staff.

Self Administration:

_____ I request that my child be allowed to carry / self-administer his/her medication.

_____ I request that my child be allowed to self-perform blood glucose testing.

I agree to and do hereby hold the District and its officers, agents, employees and/or volunteers harmless for any and all claims, demands, causes of actions, liability, damages, expenses, or loss of any sort, including bodily injury or death, because of or arising out of acts of omissions with respect to the administration of the medication(s).

Parent/guardian signature ____________________________________ Print Name: ___________________________Date ____________

Reviewed by School Nurse (signature) _______________________________ Date _______________