

**Parent Consent and Physician Authorization**  
**For Management of Diabetes at School and School sponsored Events**  
 Individualized School Healthcare Plan (ISHP) and Standard Procedures Will Provide Details for Implementation

<b>Pupil</b> _____	<b>DOB</b> _____	<b>Grade</b> _____
--------------------	------------------	--------------------

**Physician's Written Authorization: Please initial and check all boxes that apply.**

<p><b>If Insulin At School: Brand Name and Type:</b> _____</p> <p><b>Please notify the Following Personnel of my child's diabetes:</b></p> <p><input type="checkbox"/> All School Personnel   <input type="checkbox"/> Cafeteria Personnel</p> <p><input type="checkbox"/> Only Personnel that have contact with my child</p> <p><b>Dose Preparation By:</b></p> <p><input type="checkbox"/> Pupil                      <input type="checkbox"/> Syringe and vial</p> <p><input type="checkbox"/> Parent                        <input type="checkbox"/> Insulin pen</p> <p><input type="checkbox"/> Parent Designee          <input type="checkbox"/> Insulin pump</p> <p><input type="checkbox"/> Licensed nurse</p> <p><b>Basal Rate</b> _____ u/ml/hr.</p> <p><b>Insulin Bolus:</b></p> <p><input type="checkbox"/> Carb Counting: _____ # units per _____ gms Carbohydrate</p> <p><input type="checkbox"/> Morning snack    <input type="checkbox"/> Lunch            <input type="checkbox"/> Afternoon snack</p> <p><b>Insulin Administered by:</b></p> <p><input type="checkbox"/> Pupil                              <input type="checkbox"/> Parent</p> <p><input type="checkbox"/> Parent Designee              <input type="checkbox"/> Licensed Nurse</p> <p>(All parent designees are trained by the parent and are not employees of the school or district)</p> <p><b>Blood Glucose Testing:</b></p> <p><input type="checkbox"/> Before Meals                  <input type="checkbox"/> As Needed</p> <p><input type="checkbox"/> By Pupil                         <input type="checkbox"/> 2 hours postprandial</p> <p><input type="checkbox"/> Prior to exercise              <input type="checkbox"/> Needs Assistance</p>	<p><b>Care of Hyperglycemia:</b></p> <p><input type="checkbox"/> If blood glucose is _____ or above:</p> <p><input type="checkbox"/> Check ketones if blood glucose is _____ or above as follows:</p> <p><input type="checkbox"/> By Pupil independently</p> <p><input type="checkbox"/> Needs Assistance</p> <p><input type="checkbox"/> Call Physician if ketones in urine</p> <p><input type="checkbox"/> Call Parent if ketones in urine</p> <p><b>Care of Hypoglycemia when Below 70:</b></p> <p><input type="checkbox"/> Suspend pump if applicable</p> <p><input type="checkbox"/> Self treatment of mild lows</p> <p><input type="checkbox"/> Assistance for all lows</p> <p><input type="checkbox"/> 3-4 glucose tablets (15 carb)</p> <p><input type="checkbox"/> Glucagon injection for severe hypoglycemia:</p> <p style="padding-left: 20px;"><input type="checkbox"/> 0.5 mgm</p> <p style="padding-left: 20px;"><input type="checkbox"/> 1 mgm</p> <p><input type="checkbox"/> Retest in 15 minutes</p> <p><input type="checkbox"/> If &lt;70 repeat fast acting carb</p> <p><input type="checkbox"/> Retest in 15 minutes</p> <p><input type="checkbox"/> Notify Physician when: _____</p> <p><input type="checkbox"/> Notify Parent When: _____</p> <p><input type="checkbox"/> Resume pump if blood sugar is &gt;70.</p>
--	--

**Other Needs (Specify):** \_\_\_\_\_

**Parent Consent for Management of Diabetes at School**

We (I), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the following specialized physical health care service for Management of Diabetes in school be administered to our (my) child. I will provide:

1. Provide the necessary supplies and equipment
2. Notify the school nurse if there is a change in pupil health status or attending physician
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 physician when necessary.

I understand that I will be provided a copy of my child's completed Individual School Health care Plan. (ISHP)

**Parent/Guardian Signature** \_\_\_\_\_

**Physician Authorization For Diabetes Management In School**

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented. I understand that unlicensed designated school personnel may perform specialized physical health-care services. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

I have instructed \_\_\_\_\_ in the proper way to use his/her medications. It is my professional opinion that \_\_\_\_\_ should be allowed to carry and use that medication by him/herself. \_\_\_\_\_ Physician Initial

**Physician Name** \_\_\_\_\_ **Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Address** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Reviewed by School Nurse (Signature)** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed by Principal (Signature)** \_\_\_\_\_ **Date:** \_\_\_\_\_