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

Pupil **DOB** **Grade**

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

If Insulin At School: Brand Name and Type: _____

Please notify the Following Personnel of my child's diabetes:

- ☐ All School Personnel ☐ Cafeteria Personnel
- ☐ Only Personnel that have contact with my child

Dose Preparation By:

- ☐ Pupil
- ☐ Parent
- ☐ Parent Designee
- ☐ Licensed nurse

Equipment Used:

- ☐ Syringe and vial
- ☐ Insulin pen
- ☐ Insulin pump

Basal Rate _____u/ml/hr.

Insulin Bolus:

☐ Carb Counting: _____# units per _____gms Carbohydrate

☐ Morning snack ☐ Lunch ☐ Afternoon snack

Insulin Administered by:

- ☐ Pupil
- ☐ Parent
- ☐ Parent Designee
- ☐ Licensed Nurse

(All parent designees are trained by the parent and are not employees of the school or district)

Blood Glucose Testing:

- ☐Before Meals
- ☐By Pupil
- ☐Prior to exercise
- ☐As Needed
- ☐2 hours postprandial
- ☐Needs Assistance

Care of Hyperglycemia:

- ☐ If blood glucose is _____ or above:
- ☐ Check ketones if blood glucose is_____or above as follows:
  - ☐ By Pupil independently
  - ☐ Needs Assistance
  - ☐ Call Physician if ketones in urine
  - ☐ Call Parent if ketones in urine

Care of Hypoglycemia when Below 70:

- ☐ Suspend pump if applicable
- ☐ Self treatment of mild lows
- ☐ Assistance for all lows
- ☐ 3-4 glucose tablets (15 carb)
- ☐ Glucagon injection for severe hypoglycemia:
  - o 0.5 mgm
  - o 1 mgm
- ☐ Retest in 15 minutes
- ☐ If <70 repeat fast acting carb
- ☐ Retest in 15 minutes
- ☐ Notify Physician when:_____
- ☐ Notify Parent When: _____
- ☐ Resume pump if blood sugar is >70.

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:** _____

FORM A
Medication Administration Form
DIABETES PAGE 2

PERRY COUNTY SCHOOL DISTRICT

PARENT AUTHORIZATION AND INDEMNITY AGREEMENT/MEDICATIONS RELEASE:

The undersigned parent/s or guardian/s of _____, a minor child, has requested personnel(s) of the Perry County School District to administer prescription medicine by a physician to this student. This request has been made for my/our convenience as a substitute for parental administration of this medicine. It is understood that school administration will designate a school personnel(s)(who will not need a medical or nursing license) , &/or school nurse to assist/ observe my child taking the prescribed medicine ordered by a physician. I/We forever release, discharge and covenant to hold harmless the school district, its personnel and board of trustees from any claims, demands, damages, expenses, loss of services and cause of action belonging to the minor child or to the undersigned arising out of or on account of any injury, sickness, disability, loss or damages of any kind resulting from the administration of the prescription medicine. The unsigned agree to repay the school district, its personnel or trustees any sum of money, expenses, or attorney's fees that any of them may be compelled to pay in defense of any action or on account of any injury to the minor child as a result of the administration of medicine. I have read the foregoing release and indemnity agreement and fully understand it. Executed this the _____day of _____, 20_____.

_____ _____

Signature of Parent/Guardian **Witness**

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name:_____ DOB/Age_____

School_____Grade_____Teacher_____School year_____

HT_____WT_____

Allergies/Reactions_____

I request my child name and identified above to receive:

_____ Medication as prescribed by our physician on the form below or as listed on the container issued by the pharmacy.

_____Non-prescription/over-the-counter medication provided by me along with Dr.'s order

I understand and consent to the release of the information to all school personnel(s) and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I consent to communication between the prescribing physician, the pharmacist, & the school nurse necessary for the management and administration of medications pertaining to my child's medical condition. I authorize the school administration to designate a school personnel(s)(who will not need a medical or nursing license), or school nurse to assist / observe my child taking the prescribed medication order by a physician that is listed below. I understand that Perry County school district is rendering a service and does not assume any responsibility for this matter. **Name of medication**:_____

Signature of Parent/guardian_____Date_____phone#_____

Emergency Contacts: Name:_____ Phone#_____

PRESCRIBER AUTHORIZATION (TO BE FILLED OUT BY THE DR.)

StudentName:_____DOB_____Allergies:_____

Name of Medication_____ Strength [#**milligrams(MG**)]_____

Dosage **[# of pills to take/ liquid to take**]_____ Route:_____

Frequency (**Time to be given at school)_____**

Date to begin medication:_____ Date to stop med._____

Reason for taking the medication:_____

Potential side ffects/adversereactions:_____

Any special instructions or Recommendations: _____

Physician Signature:_____ Physician Name: _____

Name of Clinic:_____ Date:_____ Phone #_____

PARENTS TO FILL OUT BACK PAGE (SEE PG 3)

Perry County School District
Individualized Health Care Plan
DIABETES

*Parent need to complete this form:

StudentName:_____DOB/Grade:_____School Year:_____

Homeroom Teacher:_____ Diagnoses: **DIABETES**

Nursing Diagnosis (ND)	Nursing Intervention	Nursing goals/outcomes
1. Potential for diabetes emergencies. Risk for unstable blood glucose.	*Monitor /Encourage student to maintain glucose within goal range. *Monitor blood glucose per MD order. *Administer Insulin per MD order * Monitor and treat hypo/hyperglycemia per MD order *Have Diabetes Action plan on file.	*Student will maintain blood glucose with goal range. *Student will maintain healthy and well-being necessary for learning and action plan will be on file.

List Diabetes type:_____.

Please circle the equipment used: Insulin pen, Insulin pump, or Syringe and vial.

I_____(parent/guardian) give permission to the school administration to designate a school personnel(s)(who will not need a medical or nursing license) &/or school nurse to assist/ observe my child taking the prescribed medication which is (name of medication)_____ and to perform and carry out the care as outlined in (student's name)_____ Individualized Healthcare Plan. I also consent to the release of the information contained in this Individualized Healthcare Plan to all school personnel's and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I consent to communication between the prescribing physician, the school nurse, and the designated school personnel (which is assigned by the school administration) necessary for the management and administration of medications pertaining to my child's medical condition addressed on this Individualized Healthcare Plan. Pleases fill out the below with at least 2 Emergency contact names and phone numbers.

Parent/guardian Signature:_____Date_____Phone#_____

Emergency Contact Name 1. Name:_____ Phone# _____

2. Name:_____ Phone#_____