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** **School** **Grade**

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

1. **Blood Glucose Testing:** ☐ Before meals AND as needed
   ☐ By pupil Needs assistance
2. **Routine Care of Hypoglycemia When Below 70:**
   ☐ Self treatment of mild lows ☐ Assistance for all lows
   Notify physician when:________________
1. **Emergency Care of Severe Hypoglycemia:**
   ☐ Glucose gel: ☐ Conscious (1-2 tbsp along cheek/gumline)
   ☐ Glucagon injection: ☐ Unconscious
   0.5 mg 1 mg
   (given only by trained staff; may cause nausea/vomiting – place on his/her side.)
2. **Care of Hyperglycemia:**
   ☐ Check ketones if 300 or above as follows:
   ☐ By pupil independently ☐ Needs assistance
3. **Insulin at school:**
   ☐ Not at this time
   ☐ Lunchtime dose: use sliding scale
   ☐ Correction lunchtime dose: use sliding scale
   ☐ Correction dose: ___units for every ___mg/dl over___
   ☐ Carb Counting:____# units per _____gms Carbohydrate
   ☐ Morning snack ☐ Lunch ☐ Afternoon snack

If Insulin At School: Brand Name and Type:
____

Dose Prep/Admin By:
☐ Pupil w/supervision
☐ Parent
☐ Parent designee
☐ Licensed nurse

Equipment Used:
☐ Syringe and vial
☐ Insulin pen
☐ Insulin pump
☐ Inhaler

# of SQ Insulin Units Determined By:
☐ Pupil w/supervision ☐ Licensed nurse

Written sliding scale as follows:
Blood Glucose from 60 to150 = ______Units
Blood Glucose from 151 to 200 = ______Units
Blood Glucose from 201 to 250 = ______Units
Blood Glucose from 251 to 300 = ______Units
Blood Glucose from 301 to 351 = ______Units
Blood Glucose from 351 to 400 = ______Units
Blood Glucose > 400 = ______Units

Insulin Pump Basal Rates:
(1)______________U/hr (3)______________U/hr
(2)______________U/hr (4)______________U/hr
(All parent designees are trained by the parent and are not employees of the school or district)

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 in accordance with Education Code Section 49423.5
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 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 Healthcare Plan. (ISHP)

Parent/Guardian Signature ______________________________ **Date** ______________

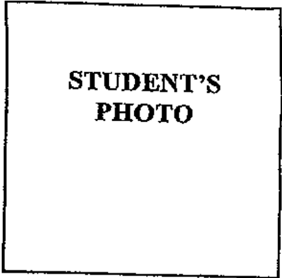
Physician Authorization For Diabetes Management In School
My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with Education Code Section 49423.5. I understand that specialized physical health care services may be 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)

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

Physician Name ____________________ **Physician Signature** ____________________ **Date** ____________

Reviewed by School Nurse (Signature) ______________________ (Date) ______________
Reviewed by Principal (Signature) ______________________ (Date) ______________

Algorithms for Blood Glucose Results



Check Blood Glucose

Below 70

1. Give fast acting sugar source*.
2. Observe for 10 – 15 minutes.
3. Retest blood glucose, if less than 70 repeat sugar source. If over 70 give carbohydrate and protein snack (eg crackers and cheese) or within one hour to next meal feed early.
4. Notify school nurse if two or more episodes in one week.

If Student Becomes Unconscious, Seizures, or is Unable to Swallow:

1. Call 911.
2. Turn student on side to ensure open airway.
3. Give glucose gel and glucagon if ordered.
4. Notify school nurse and parents

70-300

1. If student feels OK, may resume school activities.
2. If the student does not feel OK, retest blood glucose immediately.

- If 80 or below, treat for "below 70".
- If 81 or above, consult immediately with school nurse.

Above 300

Check ketones (if ordered)

Student Feels Ok – Ketones Neg. –Sm.

1. Give 1-2 glasses of water every hour.
2. Give insulin/exercise if ordered per ISHP.
3. Notify parents if small ketones are present.
4. Notify School nurse if two or more episodes occur in one week.

Student Does Not Feel OK - Ketones Mod.-Large

1. **Consult immediately with school nurse. Notify parents.**
2. Provide 1-2 glasses of water every hour.

If at any time student vomits, becomes lethargic, and/or has labored breathing CALL 911

Fast Acting Sugar Sources (15 gm carbohydrate)	
• 3-4 glucose tablets	• ½ c. apple juice
• 15 gm. glucose gel	• ½ c. grape juice
• 1/3 can sugared soda	• ½ tube cake mate gel
• ½ c. orange juice	• 3 tsp. sugar (in water)

Student's Name:	
School:	
School Nurse:	
Nurse contact number:	
Parent's phone Number:	
Alternate ER number:	