Parent Consent and Physician Authorization

For Management of Diabetes at School and School Sponsored Events

Individual School Healthcare Plan (ISHP) and Standard Procedures will provide details for Implementation

Name:	**DOB:**	**School:**	**Grade:**

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

1. **Blood Glucose Testing**: Before meals As needed

2. **Routine Care of Hypoglycemia when below 70:**
__ Self treatment of mild lows Assistance for all lows
Notify Physician when:_____

3. **Emergency Care of Severe Hypoglycemia:**
__ Glucose gel: Conscious Unconscious
__ Glucagon injection: 0.5mgm 1mgm Notify the Physician when:_____

4. **Care of Hyperglycemia:**
__ 240 or above 300 or above Other:_____
Check for ketones if 300 or above
Notify physician when: _____

5. **Insulin at School:**
__ Not at this time
__ Correction Dose (see next column)
__ Breakfast AM snack Lunch PM snack (see next column)

If insulin at school: Brand Name and Type:

_____

Insulin Administration Equipment:
__ Syringe and vial Insulin pump
__ Insulin pen Other:_____

Insulin Dose Determined By (Check all that apply**):**
__ **Standard lunchtime dose**:_____

__ **Insulin to Carbohydrate Ratio:**
• ___ # of unit(s) insulin per _gms Carbohydrate

__ **Correction Calculation:**
• Give_____unit(s) for every mg/dl above
_____mg/dl (target blood sugar)
• Decrease correction by % unit(s) if PE or increase activity is anticipated after correction dose, or last dose was given less than 2 hours before
• Other: _____
_____

___ **Written sliding scales as follows:**
Blood Glucose from_____to_____=_____Units
Blood Glucose from_____to_____=_____Units
Blood Glucose from_____to_____=_____Units
Blood Glucose from to = Units

Other Needs (specify):

Parent Consent for Management of Diabetes at School

We (I), the undersigned, the parent/guardian (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 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 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 _____
Print Name:

Physician 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 healthcare 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 school year. If changes are indicated, I will provide new written authorization (may be faxed).
____I request that the School Nurse provide me with a copy of the completed Individualized School Healthcare Plan (ISHP).

Physician Signature_____**Date**_____

Address_____**City**_____**Zip** _____
(use office Stamp)
Office Number **Fax Number**

Received by School Nurse (Signature)_____**Date** _____