



**Parent Consent and Authorized Health Care Provider Authorization for Management of
Diabetes at School and School Sponsored Events**

Individualized School Healthcare Plan (ISHP) and Procedures Will Provide Details for Implementation
(ATTACH "ALGORITHMS FOR BLOOD GLUCOSE RESULTS")

Pupil _____ DOB _____ School _____ Grade _____

PHYSICIAN'S WRITTEN AUTHORIZATION: PLEASE INITIAL AND CHECK ALL BOXES THAT APPLY

1. Blood Glucose testing:

- Before meals As needed
- By pupil Needs assistance/monitoring

2. Snacks: None Morning Afternoon

- Independent Needs reminder
- Needs verification

3. Treat low blood sugar below _____ as follows:

- Standard procedure attached Modified OK
- Self treatment of mild lows Needs assistance
- Notify physician for blood sugar below _____

4. Emergency care of severe hypoglycemia

- Glucose gel: Conscious Unconscious
- Glucagon Injection: 0.5 mg 1 mg.
- Notify Physician when _____

5. Treat high blood sugar above _____ as follows:

- Standard procedure attached Modified OK
- Record reading only, take no action.
- Notify Parent Immediately Written notice only
- Increase water intake
- Give extra Insulin (order on next column)
- Withhold or Encourage exercise
- Check ketones when blood sugar is above _____.

6. Hemoglobin A_{1c} _____ mg/dl on _____ (date)

7. If Insulin Regimen At School:

Brand name and Type: _____

Equipment Used:

- Syringe Insulin pen Insulin pump

Physician's Insulin Orders for School Administration

Sliding Scale

Blood Glucose from _____ to _____ = _____ Units

Blood Glucose from _____ to _____ = _____ Units

Blood Glucose from _____ to _____ = _____ Units

Blood Glucose from _____ to _____ = _____ Units

**In your opinion, is student independent in both
determining dose and self-administering insulin?**

- Yes No

8. Insulin Pump Regimen At School:

Snack bolus ratio _____

Blood sugar correction bolus _____

Lunch bolus ratio _____

9. Daily Carb Intake Regime Counting

Breakfast _____ # of carbs

Snack _____ # of carbs

Lunch _____ # of carbs

Snack _____ # of carbs

Dinner _____ # of carbs

Snack _____ # of carbs

Physician's Initial _____

(Signatures required on back of this form)

Parent Consent for Management of Diabetes at School

Pupil _____ DOB _____ School _____ Grade _____

We(I), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the above 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 _____

Authorized Physician for Management of Diabetes at School

My signature below provides authorization for the above written orders. This authorization is for a maximum of one 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).

I have instructed _____ in the proper way to use his/her **medications**.
(Child's Name)

It is my professional opinion that this student be allowed to carry and administer such **medications** by himself/herself. **Physician Initial** _____

Physician Name _____ Physician Signature _____ Date _____

(Print)

Address _____ City _____ Zip _____

Phone # _____ FAX # _____

For School District Personnel

Reviewed by School Nurse (Signature)

(Date)

Reviewed by Principal (Signature)

(Date)