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

Care of Hyperglycemia:

- ☐ 240 or above ☐ Other:_____
- ☐ Check ketones if 240 or above as follows:
  - ☐ By Pupil independently
  - ☐ Needs Assistance
  - ☐ Call 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.

Student is to be tested where they are immediately if they are hypoglycemic.

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 under the training and supervision provided by the school nurse 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: _____