

**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

Student _____

DOB _____

School _____ Grade _____

School Fax _____

Blood Glucose Monitoring

- before lunch before snack before leaving school
 after school activities independently Supervised

AND all suspected hypoglycemia

Meal Plan Carbohydrate amount per parent/guardian

- a.m. snack lunch p.m. snack
Extra food allowed at: parent's discretion student's discretion

Hypoglycemia Treatment Guidelines BG < _____ mg/dl

- Self treatment of mild lows, assist with moderate to severe low
 Assistance for all lows
 Immediately treat with 15 gm fast-acting carbohydrate-
e.g. 4 oz juice, 3-4 glucose tabs, 3 tsp glucose gel (cakemate)
 Recheck BG in 15 minutes and repeat above until BG > 80
 If more than 1 hour until meal give 15 gm Carb snack –
(e.g. cheese and crackers, half a sandwich)

When student experiencing low blood glucose, do not move student to a new location, until BG is above 70. Further activity may cause severe low, see information below.

Severe Hypoglycemia unconscious, seizure, unable to swallow

- Inject **Glucagon intramuscularly**, dosage _____ mg
 Lay student on side to prevent aspiration
 Call 911 Notify parent/guardian

Hyperglycemia Treatment Guidelines BG > _____ mg/dl

Access to water and bathroom breaks will be necessary

- If insulin therapy by **injection**: check ketones when BG > 350 **and** symptoms of ketosis (e.g. headache, stomach ache, nausea/vomiting)
 Insulin by **pump**: check ketones whenever BG > 350 and if ketones are present contact parent/guardian.

Ketone testing: blood ketones urine ketones

- If **moderate/large urine ketones/ > 0.6 mmol blood ketones** –
Notify parents. Student to go home. No vigorous activity.
 If negative, trace or small ketones – Give student water, access to the bathroom and student may return to usual activity.

Insulin Orders Novolog Other: _____

- No insulin at school at this time
 cannot self-administer insulin
 with supervision (dose verification)
 independently
 Changes to doses of insulin at parent discretion.

a. Insulin delivery **injection** syringe and vial or pen
Time: a.m. snack lunch p.m. snack

b. Insulin delivery **pump** – with ALL carb intake, (snack and lunch)
Must use Syringe & vial as back up when needed
Use current pump setting for meal and correction bolus

c. See Attached Plan for details of insulin dosing

P.E. and Sports Guidelines

- Carbohydrate food/beverage must be available before, during and after exercise (to treat and or prevent low blood sugar)
 If BG under 100, give 15 grams of carb before exercise.
 Do not exercise if BG over 350, has urine ketones and is not feeling well.
 Test BG as needed and provide carb snack as needed before heavy exercise

Field trips and after school activities

- Arrange for appropriate monitoring and access to supplies
MANAGEMENT PLAN REVIEWED BY

(School Nurse/Personnel name/title)

(date)

DISASTER PREPAREDNESS PLAN

Parents to provide the following supplies

- 1 vial/pen of: Rapid-acting insulin: Novolog Other: _____ Basal insulin _____
 syringes/pen needles test strips/meter Glucagon kit 15 gram fast-acting carbohydrate source pump supplies (extra battery)

In case of emergency (food not available):

- Basal Insulin** – Give _____ unit(s) of _____ at _____
 Rapid-acting Insulin - Give _____ unit(s) _____ insulin for every _____ mg/dl > _____ mg/dl every 3 hours as needed
 Insulin pump- continue regimen. If pump fails give correction dose by injection **every 3 hours** using _____ insulin, per Insulin Plan.
 Use current insulin plan provided, see attachment

PHYSICIAN AUTHORIZATION AND INSTRUCTIONS FOR DIABETES MANAGEMENT IN SCHOOL

My signature provides authorization for the written orders specified above. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that unlicensed school employees, who have received appropriate training by a school nurse or other health care professional with experience in diabetes, may perform specialized physical health care services. This authorization is for a maximum of one year.

Student has been instructed in the proper way to: check blood glucose administer insulin

It is my professional opinion that student should be allowed to:

- carry meter check blood glucose in place of choice
 carry insulin Go to school office to take insulin

MD Name _____ Signature _____ Date _____

MD Phone _____ MD FAX _____

PARENT/GUARDIAN CONSENT FOR DIABETES MANAGEMENT IN SCHOOL

I, the undersigned, request that the following specialized physical health care services for the management of diabetes in school to assist my child in accordance to the Education Code 49423. I will:

1. Provide the necessary supplies and equipment (including a copy of operating instructions)
2. Notify school Nurse/Personnel if there is a change in my child's health status or attending physician.
3. Notify the school Nurse/Personnel immediately and provide new school form/insulin plan for any regimen changes.

I authorize the school Nurse/Personnel to communicate with my child's diabetes medical team when necessary. I understand that I will be provided a copy of my child's completed Individual Health Care Plan (IHCP) or Section 504 Plan.

Parent/Guardian Signature _____ Phone _____ Date _____

