MOORPARK UNIFIED SCHOOL DISTRICT

PHYSICIAN AUTHORIZATION AND PARENT CONSENT FOR HEALTH CARE SERVICES AT SCHOOL

Student information

STUDENT'S NAME: ____ **DATE OF BIRTH**:__________

PHYSICAL CONDITION: ☐Diabetes Type 1 ☐Other ___________________

PATIENT IS CAPABLE OF independent self-management (Ind), self-management with supervision (supv) or total care (total) for the following:

Blood glucose checking	☐Ind	☐supv	☐total	Give insulin by injection	☐Ind	☐supv	☐total
Carbohydrate management	☐Ind	☐supv	☐total	Give insulin by pen	☐Ind	☐supv	☐total
Carbohydrate counting	☐Ind	☐supv	☐total	Give insulin by insulin pump	☐Ind	☐supv	☐total

Blood Glucose Monitoring

Target range of blood glucose: ☐ 70-150 ☐other

Check blood glucose with meter brought from home or additional meter left at school.
If independent, student may carry meter and check as necessary.
If supervised or total care is required, student should have blood glucose checked before lunch and if exhibiting signs/symptoms of high or low blood glucose. Student should be checked at the following times:

☐Before snacks ☐before exercise ☐before getting on bus
☐Before lunch ☐after exercise ☐other_____________

Hypoglycemia (treatment of blood glucose)

1. Treatment is given for low blood glucose less than 70 mg/dL.
2. Treat with one of the following 15 gram sugar sources: 4 oz. any type of juice, 4 oz. regular soda, 3-4 glucose tablets, 15 trams glucose gel, or 1 tablespoon sugar in water.
3. If initial blood glucose is less than 70 mg/dL, or if symptoms persist, re-check in 15 minutes and **repeat step 2 if blood glucose is still below 70 mg/dL**.
4. If lunch or snack is more than one hour away give one of the following 15 minutes after the juice:
   ☐15 gram CHO choice per parent or student
   ☐7-8 gram CHO choice per parent or student
5. Whenever possible the school nurse or trained personnel should administer Glucagon if child begins to lose consciousness, is having a seizure or is unable to swallow. This is called a **severe low blood glucose event** and it is a <u>medical emergency</u>. Glucagon can be given IM in the arm or thigh.
6. Dosage of Glucagon is ☐0.5 mg ☐1 mg
7. After treatment for a severe low blood glucose event the parent and medical team should be notified.

Hyperglycemia (treatment of high blood glucose) ☐See Insulin Pump Section

1. If blood glucose is greater than 300 mg/dL, have child wash and dry hands thoroughly and re-check glucose.
2. If blood glucose is greater than 300 mg/dL, check urine for ketones. If ketones are moderate to large, call parent. Encourage water. Student should not exercise if ketones present.

3. If blood glucose is greater than 450 mg/dL, call parent.
4. Insulin correction can be given ☐before AM snack (Mid-AM) ☐before lunch ☐other___________
5. Do not give correction more frequently than every 2 hours or if food was eaten within 2 hours.
6. Insulin for correction OR **as determined and given by parent**: ☐Humalog ☐Novolog ☐Adipra

	☐**Low Dose Scale**	☐**High Dose Scale**	☐**Other**
BG 151-200	0.5 units	1.0 units	_______________
BG 201-250	1.0 units	2.0 units	_______________
BG 251-300	1.5 units	3.0 units	_______________
BG 301-350	2.0 units	4.0 units	_______________
BG351-400	2.5 units	5.0 units	_______________
BG 401-450	3.0 units	6.0 units	_______________
BG 451-500	3.5 units	7.0 units	_______________
BG 501-550	4.0 units	8.0 units	_______________
BG 551-HI	4.5 units	9.0 units	_______________

Students on Fixed Regimen ☐N/A

☐Student is on a fixed meal plan with the following amount of carbohydrate (CHO) during school:
AM snack________________ Lunch_______________ PM snack____________
☐Student can take insulin for additional carbohydrates ___________units per _____________grams CHO
Insulin therapy in case of a disaster: For all students other than those on an insulin pump, check blood glucose every 4 hours and give insulin using scale in #7 to keep child from developing ketoacidosis.

Students on Basal Bolus Insulin Regimen with Multiple Daily Injections (MDI) ☐N/A

On this regimen, students need to take insulin every time carbohydrates are eaten!
Type of basal insulin: _________ dose: ___________ time: ________ (Usually taken at home/given by parent)
Type of bolus insulin: ☐Novolog ☐Humalog ☐Adipra
Insulin/carbohydrate ratio: ________ units per ________ grams CHO. Correction insulin: See Hyperglycemia.
Insulin therapy in case of disaster for students on MDI: Check blood glucose every 4 hours and give correction according to the hyperglycemia protocol (#7) in addition to insulin for carbohydrates.

Students with Insulin Pumps ☐N/A

(*Technical support: Call pump company number on back of pump)*
Basal rates can change often. These can be reviewed in the pump or written down by parents.
Insulin/carbohydrate ratio: one unit of insulin will cover ______________ grams CHO
Correction/Sensitivity factor: one unit of insulin will decrease blood glucose _________________ mg/dL

Insulin therapy in case of disaster for students on pump: Maintain basal rates as above with meal and correction boluses as needed. If unable to administer insulin by the pump, check blood glucose every 4 hours and give correction according to the correction protocol above in addition to insulin for carbohydrates.

STUDENT'S NAME: ______________________________________ **DATE OF BIRTH**:_______________

Exercise and Sports

The student may participate in sports: ☐Yes ☐No

Activity Restrictions: ☐None ☐Other ______________________________

Fast-acting carbohydrate should be readily available at all times for low blood glucose symptoms.

Student should not exercise if urine ketones are present or if blood glucose is less than 70 mg/dL.

Supplies to be kept at school:

A blood glucose meter and strips along with back-up insulin (vial with syringes or pen) should be available for all students. Other items that may be brought in by parents include urine ketone strips, fast-acting source of sugar, carbohydrate-containing snacks, Glucagon emergency kit, and back-up insulin pump supplies.

Other Instructions: ____

☐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.

_____________**Authorized Healthcare Provider initial**

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

Health Care Provider Authorization for Management of Diabetes at School

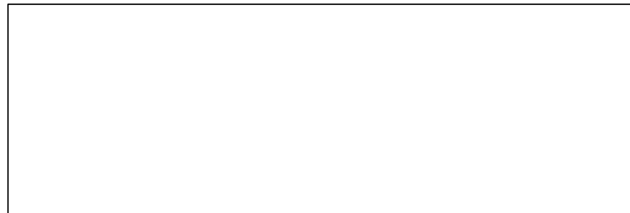
Physician Signature: ____ Date: _____________________

Address: ____

Phone: ____________________________ Fax: ______________________________

License: _____________

(Required)



Office stamp

This form is the only form that will be signed and replaces all school diabetes instructions and serves as authorization to have and receive medication at school.

Parent Consent for Management of Diabetes at School

I give permission to the school nurse, trained diabetes personnel and other designated staff members to perform and carry out the diabetes care tasks outlined in this form. I also consent to the release of the information contained in this plan to all staff members and all other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I authorize the School Nurse to communicate with the Authorized Health Care Provider when necessary.

Parent/Guardian signature: ______________________________________ Date: _____________________

______________________________________ Date: _____________________

Reviewed by the school Nurse ______________________________________ Date: _____________________