



**RYE CITY SCHOOL DISTRICT  
HEALTH CARE SERVICES  
Rye, New York 10580**

**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

|                 |             |               |
|-----------------|-------------|---------------|
| <b>Student:</b> | <b>DOB:</b> | <b>Grade:</b> |
|-----------------|-------------|---------------|

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

|  |   |
|--|---|
| <p><b>If Insulin At School: Brand Name and Type:</b> _____</p> <p><b>Please notify the Following Personnel of my child's diabetes:</b></p> <p><input type="checkbox"/> All School Personnel <input type="checkbox"/> Cafeteria Personnel</p> <p><input type="checkbox"/> Only Personnel that have contact with my child</p> <p><b>Dose Preparation By:</b></p> <p><input type="checkbox"/> Pupil <input type="checkbox"/> Parent <input type="checkbox"/> Parent Designee <input type="checkbox"/> Licensed nurse</p> <p><b>Equipment Used:</b></p> <p><input type="checkbox"/> Syringe and vial <input type="checkbox"/> Insulin pen <input type="checkbox"/> Insulin pump</p> <p><b>Basal Rate</b> _____ u/ml/hr.</p> <p><b>Insulin Bolus:</b></p> <p><input type="checkbox"/> Carb Counting: _____ # units per _____ gms Carbohydrate</p> <p><input type="checkbox"/> Morning snack <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon snack</p> <p><b>Insulin Administered by:</b></p> <p><input type="checkbox"/> Pupil <input type="checkbox"/> Parent <input type="checkbox"/> Parent Designee <input type="checkbox"/> Licensed Nurse</p> <p>(All parent designees are trained by the parent and are not employees of the school or district)</p> <p><b>Blood Glucose Testing:</b></p> <p><input type="checkbox"/> Before Meals <input type="checkbox"/> As Needed <input type="checkbox"/> By Pupil <input type="checkbox"/> 2 hours postprandial <input type="checkbox"/> Prior to exercise <input type="checkbox"/> Needs Assistance</p> | <p><b>Care of Hyperglycemia:</b></p> <p><input type="checkbox"/> 240 or above <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Check ketones if 240 or above as follows:</p> <p><input type="checkbox"/> By Pupil independently</p> <p><input type="checkbox"/> Needs Assistance</p> <p><input type="checkbox"/> Call if ketones in urine</p> <p><b>Care of Hypoglycemia when Below 70:</b></p> <p><input type="checkbox"/> Suspend pump if applicable</p> <p><input type="checkbox"/> Self treatment of mild lows</p> <p><input type="checkbox"/> Assistance for all lows</p> <p><input type="checkbox"/> 3-4 glucose tablets (15 carb)</p> <p><input type="checkbox"/> Glucagon injection for severe hypoglycemia:</p> <p><input type="checkbox"/> 0.5 mgm</p> <p><input type="checkbox"/> 1 mgm</p> <p><input type="checkbox"/> Retest in 15 minutes</p> <p><input type="checkbox"/> If &lt;70 repeat fast acting carb</p> <p><input type="checkbox"/> Retest in 15 minutes</p> <p><input type="checkbox"/> Notify Physician when: _____</p> <p><input type="checkbox"/> Notify Parent When: _____</p> <p><input type="checkbox"/> Resume pump if blood sugar is &gt;70.</p> <p><b>Student is to be tested where they are immediately if they are hypoglycemic.</b></p> |
|--|---|

**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. 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:** \_\_\_\_\_

