LAS VIRGENES UNIFIED SCHOOL DISTRICT

4111 Las Virgenes Road, Calabasas, CA 91302

PARENT CONSENT AND HEALTHCARE PROVIDER AUTHORIZATION FOR MANAGEMENT OF DIABETES AT SCHOOL

Name of Student _____ Birthdate _____

School _____ Grade _____

Diagnosis: ❑ Diabetes Type 1 ❑ Diabetes Type 2 ❑ Other _____

Student Competency: *Independent self-management (ind), self-management with supervision (supv) or total care (total) for the following:*

Blood glucose testing ❑ Ind ❑ supv ❑ total care Carbohydrate counting ❑ Ind ❑ supv ❑ total care

Insulin administration ❑ Ind ❑ supv ❑ total care Urine Ketone testing ❑ Ind ❑ supv ❑ total care

Hypoglycemia ❑ Ind, unless cognition impaired ❑ supv ❑ total care

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Target Blood Glucose (BG) Range: ❑ 70 - 120 mg ❑ 70 -150 mg ❑ other _____

HbA1c: Results: _____ Date: _____

Blood Glucose Monitoring at School: ❑ before snacks ❑ before PE/recess ❑ after PE/recess ❑ before lunch ❑ before getting on bus

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Carbohydrate (CHO) Count and Insulin Administration

Carbohydrate ratio = flexible dosing using _____ unit(s) per _____ grams carbohydrate

❑ #CHOs am snack_____ ❑ #CHOs lunch_____ ❑ #CHOs pm snack_____

Indicate any other dietary accommodations (class parties, etc.): _____

Insulin Administration: *Insulin may be administered by the student, licensed nurse, or parent/guardian at school.*

Administer Insulin at School: ❑ **YES** ❑ **NO** *Type of Insulin:* _____

Hyperglycemia: Treatment of Hyperglycemia

Step 1	Have student wash hands and dry thoroughly, and repeat if blood sugar is greater than 300 mg.
Step 2	Check for urine ketones if BG > 300, two times or it is more than 3 hours after last meal. Do not allow student to exercise if ketones are present. Encourage water. • If ketones are present, contact parent/guardian • Notify District Nurse (who will contact the physician for moderate to large ketones)
Step 3	Even if ketones are ***not*** present, if BG is > _____mg, call physician and parent
Step 4	If no ketones present, send back to class or regular routine with extra water.

Physical Exercise: (fast-acting carb should be readily available at all times for low blood glucose symptoms)

❑ Do not exercise if BG is < _____mg, or > _____mg with ketones present

❑ Activity restrictions: ❑ None ❑ Other _____

Daily Base Dose: ❑ daily before lunch _____ units SQ

❑ daily before am/pm (circle one) snack _____ units SQ.

❑ before afternoon snack _____ units SQ

Method of administration: ❑ Syringe ❑ Pen ❑ Pump (see below)

Insulin correction will not be given more frequently than every 2 hours, or if food was eaten within 2 hour without consent from physician and parent/guardian.

Correction: ❑ before snacks ❑ before lunch (sliding scale *used in addition to basal dose)*

BG 151-200 = _____units
BG 201-250 = _____units
BG 251-300 = _____units
BG 301-350 = _____units
BG 351-400= _____units
BG 401-450 = _____units
BG 451-500 = _____units

❑ Other: BG ____ - ____ = ____ units
BG ____ - ____ = ____ units
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BG ____ - ____ = ____ units
BG ____ - ____ = ____ units
BG ____ - ____ = ____ units

Students with Insulin Pumps (for technical support call pump company on back of pump)

Date started on pump: _____ Type of pump: _____ Type of Insulin *in* pump: _____

Student: ❑ call parent for all programming ❑ student programs dose manually

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***Hypoglycemia* : Treatment of MILD-MODERATE LOW BLOOD BLUCOSE (BG)**

Step 1	Treatment is given for blood glucose less than 70 mg/dL.
Step 2	Give 15 grams of **readily available** fast acting carbohydrate
Step 3	Notify school nurse and/or parent/guardian.
Step 4	IF initial blood glucose is < 60 or symptoms persist, monitor for 10 - 15 minutes, then: • Retest. If BG is <70 mg/dL or if symptoms persist/recur, repeat Steps 2 & 3 • If symptoms subside and BG is >70 mg **and** if lunch or snack **is more than one hour away**, give 15 grams complex carbohydrates. If symptoms subside and/or BG is >70 mg, resume usual activity.

Treatment of SEVERE LOW BG ***(combative or unable to swallow, unresponsive/unconscious, seizure)***

Step 1	Administer Glucagon IM or SQ: DOSE: ❑ 0.3 mg ❑ 0.5 mg ❑ 1 mg
Step 2	**Call 911.** Keep student on side. Ensure open airway.
Step 3	Notify parent/guardian and school nurse.

❑ **Parent may advise licensed nurse to increase insulin dose up to _____%, without MD approval.**

I, the undersigned, recommend the Specialized Physical Health Care Services as indicated.

Physician Signature _____

Phone _____ Date _____

Physician's Stamp

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 other adults who have custodial care of my child and who may need to know this information in order to maintain my child's health and safety.

Parent/Guardian: _____ **Date:** _____

Return this form to School Health Office
Rev: 5/2016

AUTHORIZATION FOR MEDICATIONS TAKEN DURING SCHOOL HOURS, SCHOOL ACTIVITIES AND FIELD TRIPS

Valid *only* for the current school year or as designated in the Individual Education Program (IEP) for Special Education students.

EXCEPTION: California Education Code 49423.5 - Specialized services, i.e., EpiPen, nebulizer, glucagon, insulin, diabetes care, etc., may require additional forms and instructions signed by Parent or Legal Guardian and Physician. Request *specialized services forms* from school.

PARENT OR LEGAL GUARDIAN

Parent or Legal Guardian Section

Note: All medications must be prescribed, including over-the-counter medications. Medications must be in the original container and the label must include the child's name, name of the medication, dosage, method of administration, time schedule and name of physician

I request that designated unlicensed, trained school staff or licensed nurse assist my child in taking this prescribed medication(s) (including prescribed over-the-counter medication). I understand that my child may not be assisted with medication at school until all requirements are met. I hereby give consent for a school nurse (or designee) to communicate with my child's prescriber and to counsel school personnel as needed with regard to my child's health. I agree to, and do hereby hold the District and its employees harmless for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of acts or omissions with respect to this medication. I agree to comply with district rules related to administering medication at school.

Name of Child ______ M F Sex ______ Birth Date ______ Student Identification Number ______

Name of School ______ Grade ______ Teacher/Room Number ______

List all medications routinely taken outside of school hours: ______

I will immediately notify the school if there are any changes in medications my child is taking at school.

Signature of Parent or Legal Guardian ______ Date ______ Home/Mobile Telephone ______ Work Telephone ______

PHYSICIAN

Physician Section

The child named above is under my care for these diagnoses: ______

It is necessary for him or her to receive the following prescribed medication(s) during schools hours.

Name of Medication ______ Dosage (be specific, i.e. milligrams, etc.) ______
Time of day to be given ______ Frequency and Indication if "as needed" ______
Method of administration ______ Duration ______
Precautions or side effects ______
Storage and handling
- ☐ Routine handling, medication in locked storage and administered by authorized school personnel
- ☐ On-site 72 hour disaster supply only
- ☐ It is *Medical Necessity* for child *to carry* prescription for asthma, anaphylactic shock or diabetes, and indicate:
  - ☐ Designated school personnel to administer
  - ☐ Child trained to self-administer

Name of Medication ______ Dosage (be specific, i.e. milligrams, etc.) ______
Time of day to be given ______ Frequency and Indication if "as needed" ______
Method of administration ______ Duration ______
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Stamp physician name/address below:

Signature of Physician ______ Date ______

Name of Physician (please print) ______ License Number ______ Office telephone ______

Legal References: California Ed Code sections 49423-49423.5 and Department of Education, "Program Advisory on Medication Administration, May 2005," updated June 2012

White – School District Canary – Parent or Legal Guardian Pink – Physician or Licensed Health Care Provider

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