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

Student:	**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:
  - 0.5 mgm
  - 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. 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: _____