San Mateo Union High School District

Parent Consent and Authorized Health Care Provider Authorization

For Management of Diabetes at School and School Sponsored Events

Student: ______________________ **DOB:** ________ **School:** ____________ **Grade:** ______

Authorized Health Care Provider's Written Authorization: Please fill in lines and check all boxes that apply.

1. Blood Glucose Checking:

When:
- ☐ For suspected hypoglycemia
- ☐ Before snacks
- ☐ Before meals
- ☐ Before exercise
- ☐ Before getting on bus

How:
- ☐ By student independently. Allow student to carry supplies
- ☐ By student with staff supervision
- ☐ Needs assistance by trained staff

BG Target at school: ______ to ______ mg/dL

2. Routine Care of Hypoglycemia (BG < 70)
- *see flow chart*
- Never leave student alone if low is suspected

☐ Self treatment of mild lows
☐ Needs assistance for all lows

3. Care of Severe Hypoglycemia
(unconscious, combative, or unable to swallow)
- *see flow chart*
- Give glucose gel in side of cheeks
- Administer glucagon by intramuscular injection ☐ 0.5mg ☐ 1 mg
- then **call 911**
- notify parent/guardian

4. Care of Hyperglycemia (BG > 300)
- *see flow chart*
- Check urine or blood ketones

☐ At student's discretion
☐ Ketones checked by school staff
☐ Ketones checked by student with staff verification

5. Diet

☐ No restrictions, at student's discretion
☐ Lunch to be eaten between _____ am & _____ pm
☐ To avoid hypo/hyperglycemia, lunch should consist of ____ to ____ grams of carbohydrates
☐ Snack(s) at ____ am and/or ____ pm
☐ Extra snack allowed before/during exercise *without insulin coverage*

6. Insulin at School: ☐ Yes ☐ No
Type: Humalog or Novolog per student's discretion
☐ Before snacks ☐ Before lunch
☐ Before all carbohydrates *unless treating or preventing hypoglycemia*

7. Dose Prepared By:
- ☐ Student independently
- ☐ Guardian
- ☐ As designated by guardian
- ☐ Staff
- ☐ Student with staff verification

Equipment Used:
- ☐ Syringe and vial
- ☐ Insulin pen
- ☐ Insulin pump
- ☐ Student to carry his/her insulin at all times and independently decide on insulin doses

8. Insulin dose administered by:
- ☐ Student independently
- ☐ Guardian
- ☐ As designated by guardian
- ☐ Staff
- ☐ Student with staff verification

9. Insulin dose:

☐ At student's discretion
☐ Use bolus wizard or pump calculator to determine
☐ Insulin to carb ratio: _____ unit(s) for every _____ grams
☐ Correction Calculation: (at lunch only)
Give ____ unit(s) for every _____ above _____ mg/dL
Corrections should not be repeated more than every 3 hours
☐ Ok to use most recent insulin dose scale for lunch corrections and carbs
☐ Ok to decrease insulin dose by 20% if intense exercise is anticipated

10. Disaster Plan, goals of management of child with diabetes during a disaster is to 1) Prevent severe lows, 2) prevent diabetic ketoacidosis.

☐ Student to use insulin plan as above for meals
☐ Student to take Lantus: ____ units am or____ units pm
☐ Give correction dose every 3 hours
give ____ unit(s) for every _____ above _____ mg/dL

11. Student to be allowed to call guardian any time for diabetes related issues.

12. Other: ______________________________

The signatures below provide authorization for the above written orders and show agreement that all procedures must be implemented in accordance with state laws and regulations. This authorization is for a maximum of one year. If changes are indicated, new written authorization or a signed addendum to this form will be needed.

Las firmas escritas abajo autorizan a que se lleven a cabo las órdenes arriba descriptas, e indican la aceptación de que todos los procedimientos deberán ser implementados de acuerdo con las leyes y reglamentaciones estatales. Esta autorización tendrá vigencia por un año. Si llegara a indicarse algún cambio, se necesitará una nueva autorización por escrito o una enmienda firmada de este formulario.

Authorized Health Care Provider Name: ______________________ Signature ______________

Address ______________________ City ____________ State _____ Zip ______

Date: ______________ Phone: ______________

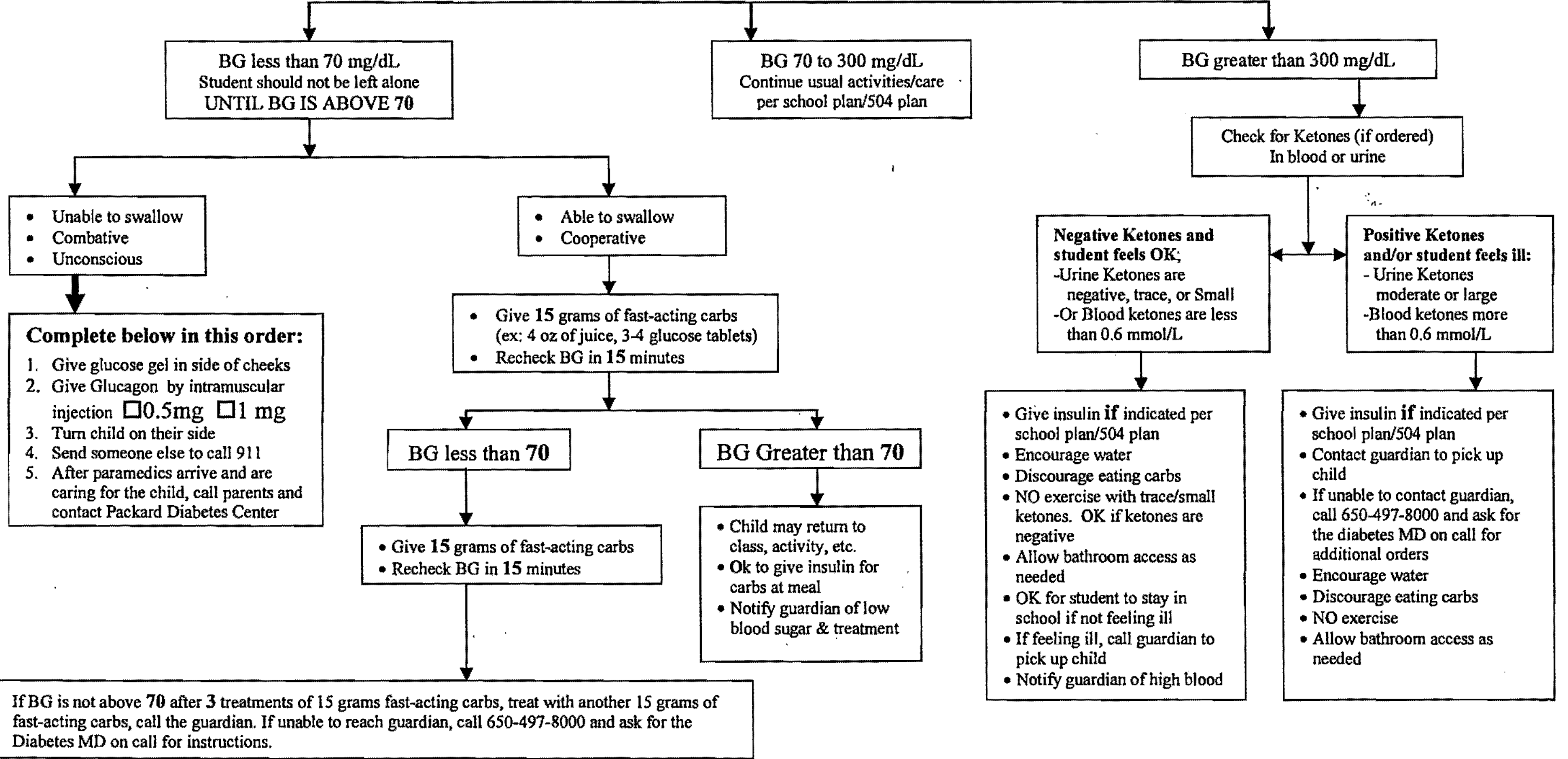
Parent(s)/Guardian(s) Signature ______________________ Date ________

School Nurse Signature ______________________ Date ________

Diabetes Management Flow Chart
Check Blood Glucose (BG)

- At designated times per school plan /504 plan
- If student complains of signs/symptoms of hypoglycemia/hyperglycemia
- If signs/symptoms of hypoglycemia/hyperglycemia are observed in student

Name: ____________________
DOB: ____________________
School: ____________________
School Fax: ____________________



Signs & Symptoms of a Low Blood Sugar (Hypoglycemia)

Can include: shakiness; nervousness; sweating; irritability, sadness, or anger; impatience; chills and cold sweat; fast heartbeat; light-headedness or dizziness; hunger; drowsiness; stubbornness or combativeness; lack of coordination; blurred vision; nausea; tingling or numbness of lips or tongue; headache; strange behavior; confusion; personality change; passing out; ______________; __________

Signs & Symptoms of a High Blood Sugar (Hyperglycemia)

Can include: nausea; vomiting; stomach pain; fruity-smelling breath; lack of appetite; frequent urination; extreme thirst; weakness; blurry vision; warm, flushed skin; drowsiness; breathing problems; unconsciousness; ______________;

Emergency Contact Info

Name: ____________________
Phone #1 ____________________
Phone #2 ____________________
Phone #3 ____________________
Alternate contact person: ____________________
Phone Number: ____________________

SAN MATEO UNION HIGH SCHOOL DISTRICT
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization. I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services at school.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: ____

Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) ____________________________________ (2) ____

to provide health information from the above-named student's medical record to and from:

San Mateo Union High School District	**650 North Delaware St., San Mateo, CA 94401**
School District to which disclosure is made	Address/City and State/Zip Code
Sara Devaney, Health Services Manager	**650-558-2222 (Confidential Fax 650-762-0250)**
Contact person at School District	Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

____

Requested information shall be limited to the following: □ All health information; or □ Disease-specific information as described:

____

DURATION: This authorization shall become effective immediately and shall remain in effect until ___________ (enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS: California law prohibits the School District from making further disclosure of my health information unless the School District obtains another authorization form from me or unless such disclosure is specifically required or permitted by law. I understand that the School District will protect this information as prescribed by the Family Educational Rights Privacy Act (FERPA) and state law and that the information becomes part of the student's education record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs. *If you move to another School District, records will be transferred automatically to that School District.*

YOUR RIGHTS: I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the School District or others have acted in reliance to this Authorization.*

APPROVAL: ________________________ ____________________________ ______________

Printed Name Signature Date

____________________________ ______________________________________

Relationship to Patient/Student Area Code and Telephone Number

SAN MATEO UNION HIGH SCHOOL DISTRICT
AUTORIZACIÓN PARA USAR Y/O DIVULGAR INFORMACIÓN SOBRE LA SALUD DEL ESTUDIANTE

Completar este documento autoriza la divulgación y/o el uso de información sobre la salud del estudiante. Esta información revela la identidad de la persona, como se expresa más abajo, en concordancia con las leyes de California y las leyes federales en cuanto a la privacidad de dicha información. Esta autorización podría invalidarse si la información que se proporciona está incompleta. Tengo el derecho de recibir una copia de esta Autorización. Para que la escuela pueda dar a este estudiante los servicios que necesita, es probable que (yo) tenga que firmar esta autorización.

USO Y DIVULGACIÓN DE LA INFORMACIÓN:

Nombre del paciente/estudiante: ____

Apellido/Primer nombre/Inicial del segundo nombre/Fecha de nacimiento

Yo, el/la abajo firmante, por el presente autorizo a (nombre de la agencia y/o profesionales médicos):

(1) ________________________________ (2) ________________________________

a proporcionar la información sobre la salud del estudiante mencionado arriba, contenida en la historia clínica de éste, y a que la intercambie con:

San Mateo Union High School District	**650 N. Delaware Street, San Mateo CA 94401**
Distrito escolar receptor de dicha divulgación	Domicilio/ciudad y estado/código postal
Sara Devaney, Health Services Manager	**650-558-2222 (Confidential Fax 650-762-0250)**
Persona de contacto en el distrito escolar	Código de área y número de teléfono

La divulgación de la salud del estudiante se requiere para los siguientes propósitos:

____

La información solicitada estará limitada a: □ Información completa sobre la salud del estudiante o □ información sobre una enfermedad en particular, como se describe a continuación:

____

DURACIÓN: Esta autorización entrará en vigor inmediatamente y permanecerá vigente hasta ___________ (escriba la fecha) o durante un año después de la fecha en que se haya firmado (si no se especifica otra fecha).

RESTRICCIONES: Las leyes de California prohíben al distrito escolar que continúe divulgando la información sobre la salud del estudiante, a menos que obtenga mi autorización (otra distinta a esta) o a menos que tal divulgación haya sido específicamente requerida o permitida por la ley. Entiendo que el distrito escolar protegerá esta información, como lo define la Ley de Derechos Educacionales y de Privacidad de la Familia (FERPA) y la ley estatal, y que la información formará parte del expediente del estudiante. La información será compartida con individuos que trabajan en/con el distrito escolar con el propósito de brindar ambientes educacionales, servicios y programas de salud escolares que sean seguros, apropiados y menos restrictivos. Si el estudiante se muda a otro distrito escolar, sus expedientes serán transferidos automáticamente al nuevo distrito.

SUS DERECHOS: Entiendo que tengo los siguientes derechos con respecto a esta Autorización: Puedo revocarla en cualquier momento. Mi revocación debe ser por escrito, firmada por mí o en mi representación, y entregada a las agencias/personas relacionadas con la atención médica mencionadas arriba. Mi revocación entrará en vigor en cuanto sea recibida; sin embargo, la misma no tendrá efecto alguno sobre los actos previos del distrito escolar que fueron realizados conforme a esta autorización.

APROBACIÓN: ______________________ ______________________ __________

Nombre (escriba, por favor) Firma Fecha

______________________ ______________________

Parentesco con el paciente/estudiante Código de área y número de teléfono