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 the bus

How:
- ☐ By student independently. Allow student to carry all 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 for mild lows
- ☐ Needs assistance for all lows

3. Care of Severe Hypoglycemia (unconscious, combative, or unable to swallow)

- See flow chart
- Give glucose gel inside of cheeks

Administer glucagon by intramuscular injection ☐ 0.5mg ☐ 1 mg

- Then call 911
- Notify parent/guardian

4. Care of Hypoglycemia

- 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 _____ a.m. & _____ p.m.
- ☐ To avoid hypo/hyperglycemia, lunch should consist of _____ - _____ grams of carbohydrates.
- ☐ Snack(s} at _____ a.m. and/or _____ p.m.
- ☐ 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

Continued on next page

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
- ☐ 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:
  _____ units 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 and 2. prevent diabetic ketoacidosis.

- ☐ Student to use insulin plan as above for meals
- ☐ Student to take Lantus: _____ units a.m. or _____ units p.m.
- ☐ Give correction dose every three hours. Give _____ unit(s) for every _____ above _____ mg/dL

11. Student is allowed to call guardian anytime 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 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 Healthcare Provider Name: _____

Address: _____

Phone: _____ Date: _____

Parent(s)/Guardian(s) Signature: _____ Date: _____

School Health Team 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

Student Name: _____ DOB: _____

School: _____ School Fax: _____

Emergency Contact: _____

Phone: _____ Alternate Phone: _____

Alternate Contact Person: _____

Phone Number: _____

BG less than 70 mg/dL

Student should not be left alone
UNTIL BG IS ABOVE 70

- Unable to swallow
- Combative
- Unconcious

Complete below in this order:

1. Give glucose gel in side of cheeks
2. Give Glucagon by intramuscular injection:
   ☐ .5 mg ☐ 1 mg
3. Tum child on their side
4. Send someone to call 911
5. After paramedics arrive and are caring for the child, call parents and contact Packard Diabetes Center at 650-497-8000.

- Able to swallow
- Cooperative

- Give 15 grams of fast acting carbs (Ex: 4 oz of juice, 3-4 glucose tablets)
- Recheck BG in 15 minutes

BG less than 70

- Give 15 grams of fast acting carbs (Ex: 4 oz of juice, 3-4 glucose tablets)
- Recheck BG in 15 minutes

BG greater than 70

- Child may return to class, activity, etc.
- Ok to give Insulin for carbs at meal
- Notify guardian of low blood sugar and treatment

If BG is not above 70 after three treatments of 15 grams fast-acting carbs, treat with another 15 grams of fast-acting carbs, call the guardian. If unable to reach guardian, call 650-497-8000 and ask for the Diabetes MD on call for instructions.

BG 70 to 300 mg/dL

Continue usual activities/care per school plan/S04 plan

BG greater than 300 mg/dL

Check for Ketones (if ordered) in blood or urine

Negative Ketones and student feels ok

- Urine Ketones are negative, trace, or small
- Or blood Ketones are less than 0.6 mmol/L

- Give insulin if indicated per school plan/504 plan
- Encourage water
- Discourage eating carbs
- NO exercise with trace/small ketones. OK if ketones are negative
- Allow bathroom access as needed
- OK for student to stay in school if not feeling ill
- If feeling ill, call guardian to pick up child
- Notify guardian of high blood sugar

Positive Ketones and/or student feels ill

- Urine Ketones moderate or large
- Blood Ketones more than 0.6 mmol/L

- Give insulin if indicated per school plan/504 plan
- Contact guardian to pick up child
- If unable to contact guardian, call 650-497-8000 and ask for the diabetes MD on call for additional orders
- Encourage water
- Discourage eating carbs
- NO exercise
- Allow bathroom access as needed

Signs and Symptoms of a Low Blood Sugar (Hypoglycemia)
Can include: shakiness; nervousness; sweating; irritability, sadness, or anger; impatience; chills and cold sweat; fast heartbeat; lightheadedness 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; fmity-smelling breath; lack of appetite; frequent urination; extreme thirst; weakness; blurred vision; warm, flushed skin; drowsiness; breathing problems; unconsciousness; _____.

San Mateo Union High School District
Authorization for Medication(s) to be Taken During School Hours

Pursuant to Section 49423 and subdivision (b) of Section 49423.6 of the California Education Code, any pupil who is required to take, during the regular school day, prescribed medication may be assisted by a school nurse or other designated school personnel if both of the following conditions are met: (a) The pupil's authorized health care provider executes a written statement specifying, at a minimum, the medication the pupil is to take, the dosage, and the period of time during which the medication is to be take, as well as otherwise detailing (as may be necessary) the method, amount, and time schedule by which the medication is to be taken. (b) The pupil's parent or legal guardian provides a written statement initiating a request to have the medication administered to the pupil or to have the pupil otherwise assisted in the administration of the medication, in accordance with the authorized health care provider's written statement.
With the approval of the pupil's authorized health care provider and the approval of the pupil's parent or legal guardian, a local education agency may allow a pupil to carry medication and to self-administer the medication.

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PARENT: School Name_____

Student Name _____Gender_____ Date of Birth_____
Last First

_____(_____)_____
Physician/Health Care Provider's Name Address Telephone

In regards to the medication authorized below by her/his physician/health care provider:

I request that my student be assisted in taking the medicine(s) at school by authorized persons: Yes_____ No_____

I request that my student be permitted to carry medication & self-medicate her/himself: Yes_____ No_____

I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of the original prescription; strength and dose of medication; and directions for use. If medication is kept at school in the health office, it will be destroyed unless picked up within one week after the end of the school year or end of the medical order. I have read and signed the attached consent (reverse side) to allow designated school personnel to consult with my student's health care provider regarding medication questions. I understand that the medication may be discontinued with written parental request. As parent/guardian of the above-named student, I hereby indemnify and hold harmless from any demands, actions, suits, or liability of any nature or kind, any and all personnel, employees, and agents of the San Mateo Union High School District who may act pursuant to the instruction of my student's health care provider.

_____ _____ (_____)_____(_____)_____
Date Signature of Parent/Guardian Home Phone Emergency

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN:

Diagnosis for which medication is given:_____

Name of medication:_____

Form: _____Dose & route: _____

If medicine is to be given DAILY, at what time(s):_____

If medicine is to be given WHEN NEEDED, describe indications: _____

How soon can it be repeated?: _____ Length of time this treatment is recommended: _____

List significant side effects of medication: _____

In my opinion, this student shows the capability to carry and self-medicate the above medication: Yes_____ No_____

If necessary, this medication may be safely and appropriately administered by trained unlicensed school personnel: Yes_____ No_____ N/A_____

Date: _____ **Signature of Authorized Health Care Provider:** _____

Health Care Provider Address Stamp (required):

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