## Parent Consent and Licensed Healthcare Provider Authorization For Diabetes Management In School and School Sponsored Events

Individualized School Healthcare Plan (ISHP) and Standard Procedures Will Provide Details for Implementation

Pupil DOB	School Grade
Licensed Healthcare Provider's Written Authorization: Please initial and check all boxes that apply	
1. Blood Glucose Testing:	6. Licensed Health care provider verification: Student can perform the
Before am snack	following procedures (parent and school nurse must verify competency as well):
Before lunch	☐ Blood glucose testing ☐ Measuring insulin ☐ Injecting insulin
2 hours after lunch	Determining insulin dose Independently operate insulin pump
2 hours after a correction dose	other:
	7. Insulin Orders (complete only if insulin is needed at school):
For suspected Hypoglycemia	Brand Name and type:
At students discretion excluding suspected hypoglycemia	* *
Only at students discretion	Administration times (fill in times only those that apply):
No blood glucose testing at school	☐ Breakfast ☐ AM snack ☐ Lunch ☐ PM snack
Target range for blood glucose testing at school:	Other:
2. Hypoglycemia-blood glucose less than 70:	Insulin administration via:
Self treatment of mild lows Assistance for all lows Provide extra	Syringe Insulin pump Insulin pen
protein & carb snack after treating lows or feed snack/meal early (if scheduled	Other:
within the hour).	Insulin dose determined by (Check all that apply):
Okay to use glucose gel inside check; even if unconscious	Food/bolus doses:
Glucagon injection IM (for severe hypoglycemia): 0.5mgm 1mgm	standard lunchtime dose:
(Refer to attached "Algorithms for Blood Glucose Results" for summary of treatment	
procedures)	Insulin to carbohydrate ratio:
3. Hyperglycemia	# unit(s) insulin per gms Carbohydrate
☐ If blood glucose>initiate insulin administration order	Correction Calculation (complete only those that apply):
☐ If blood glucose>or exhibit symptoms of ketosis, check ketones.	<ul> <li>Give unit(s) for every mg/dl above mg/dl</li> </ul>
☐ Check urine ketones ☐ Check blood ketones.	<ul> <li>Decrease correction by % unit(s) if PE or increased activity is</li> </ul>
(Refer to attached "Algorithms for Blood Glucose Results" for summary of treatment	anticipated after correction dose, or last dose was given less than 2
procedures)	hours before. OR
4. Meal Plan	Written on slide scale as follows:
Snacks/Meals: Mandatory At student's discretion	Blood Glucose fromto=Units
	Blood Glucose fromto=Units
AM snack time: PM snack time:	Blood Glucose fromto=Units
Lunch time: Other:	Blood Glucose from to = Units
☐ Extra food allowed: ☐ Parent's discretion ☐ Student's discretion	
5. Exercise (Check and/or complete all that apply)	Add carb calculation insulin dose and correction calculation for total insulin
Liquid and solid carb sources must be available before, during and after all exercise.	dose/bolus
No exercise if most recent blood glucose is <70.	8. Bus Transportation:
Eatgms CHO for vigorous exercise:	Blood glucose test not required prior to boarding bus.
☐ Before ☐ Every 30 min. during, ☐ After	Test blood glucose 10 to 20 minutes before boarding bus
☐ No exercise when blood glucose is > or ketones present	<ul> <li>Provide 15 gm glucose source if blood glucose is &lt; mmg/dl</li> </ul>
The exercise when blood glacose is or ketones present	Provide care as follows:
	Other Needs: Specify on physician stationary or prescription pad and attach.
Licensed Health Care Provider Authorization For Diabetes Management In School	
My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations.	
I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).	
Licensed Healthcare Provider Name: Signature	ePhone
AddressCity	_Zip
☐ I have instructed in the proper way to use his/her medication	s. It is my professional opinion that should be allowed to carry
(Child's Name)	(Child's Name)
and use that medication by him/herself Licensed Healthcare Provider Initial	
☐ I request that the School Nurse provide me with a copy of the completed Individualized School Healthcare Plan (ISHP).	
Parent Consent for Diabetes Management In School	
I (we) 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 my (our) child in accordance with state laws and regulations.  I (we) will:	
1. Provide the necessary supplies and equipment	
2. Notify the school nurse if there is a change in pupil health status or attending licensed healthcare provider.	
3. Notify the school nurse immediately and provide new consent for any changes in licensed healthcare provider's orders,	
I (we) give consent for the school nurse to communicate with the licensed healthcare provider when necessary.	
I (we) understand that I (we) will be provided a copy of my child's completed Individual School Healthcare Plan. (ISHP)	
Parent/Guardian Signature Date	
Date	
Reviewed by School Nurse (Signature) Date	