

**Covina-Valley Unified School District**  
**Parent Consent and Physician Authorization**  
**For Management of Diabetes at School and School Sponsored Events**

**Student:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

|                                          |            |             |                                           |   |   |
|------------------------------------------|------------|-------------|-------------------------------------------|---|---|
| <b>Self-Care:</b>                        | Total Care | Supervision | Independent                               |   |   |
| Can student give own injection?          |            | Y N         | Can student draw correct dose of insulin? | Y | N |
| Can student calculate amount of insulin? |            | Y N         | Can student self administer insulin?      | Y | N |

**Insulin at School:**

Type of bolus insulin: \_\_\_\_\_  
 Administer insulin bolus: Before breakfast Before AM snack Before Lunch Other  
 Insulin correction may be administered as often as every \_\_\_\_\_ hours if needed.

**Blood Glucose Monitoring**

Target range for blood glucose: \_\_\_\_\_ mg/dL to \_\_\_\_\_ mg/dL

Check blood glucose: Before lunch As needed Other

Student wears Continuous Glucose Monitor: Yes No

**Sliding Scale**

|          |                                                 |
|----------|-------------------------------------------------|
| AM snack | Blood Glucose from _____ to _____ = _____ units |
| Lunch    | Blood Glucose from _____ to _____ = _____ units |
|          | Blood Glucose from _____ to _____ = _____ units |

**Disaster/Lock down Protocol:**

|           | Time of Day | Humalog/Novolog | NPH | Lantus |
|-----------|-------------|-----------------|-----|--------|
| Breakfast |             |                 |     |        |
| Lunch     |             |                 |     |        |
| Dinner    |             |                 |     |        |
| Bedtime   |             |                 |     |        |

**Emergency Supplies:**

- |                                               |                                     |
|-----------------------------------------------|-------------------------------------|
| 1. Prescribed medications for at least 3 days | 3. Food supplies for 3 days         |
| 2. Glucagon and urine ketostix                | 4. Emergency syringes if using pump |
- Check blood glucose every 4 hours and give correction dose

**Students on a Basal-Bolus Insulin Regimen with Multiple Daily injections (MDI)**

N/A

On this regime students need to have insulin given every time carbohydrates are eaten.

- Bolus: Type of Insulin \_\_\_\_\_ Insulin & Syringes Insulin pen Insulin pump
- Insulin Carbohydrate ratio: \_\_\_\_\_ units per \_\_\_\_\_ grams of CHO
- Correction Dose: \_\_\_\_\_ unit per \_\_\_\_\_ points of blood glucose above \_\_\_\_\_

**Disaster/Lockdown Protocol:** Basal insulin \_\_\_\_\_ Dose \_\_\_\_\_

**Students with Insulin Pump**

|                                |                         |            |
|--------------------------------|-------------------------|------------|
| Type of insulin in pump: _____ | Basal rates: Time _____ | Dose _____ |
| Student programs dose manually | Time _____              | Dose _____ |
| uses bolus wizard/calculator   | Time _____              | Dose _____ |

- Type of infusion set: \_\_\_\_\_
- Insulin/Carbohydrate ratio: 1 unit of insulin covers \_\_\_\_\_ grams CHO for breakfast  
 1 unit of insulin covers \_\_\_\_\_ grams CHO for lunch
- Correction Dose: 1 unit of insulin will decrease blood glucose \_\_\_\_\_ mg/dL
- For technical support, call the pump company number on the back of the pump. For clinical support, call the clinic.

**If unable to administer insulin by pump check blood glucose every 4 hours and give correction via syringes or insulin pen according to the correction dose above in addition to insulin for carbohydrates.**

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**Disaster/Lockdown Protocol**

Maintain basal rates as above with the meal and correction bolus as needed.

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**Exercise and Sports**

The student may participate in sports:

Yes

No

Activity Restrictions:

None

Other:

Fast-acting carbohydrates must be readily available when exercising or participating in sports.

Student should not exercise if urine ketones are present or if blood glucose is less than 70mg/dL

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**Hypoglycemia**

1. If below 70 mg/dl treat with 4 oz. juice, 4-6 oz. regular soda, 4 glucose tablets, 1 tube of glucose gel, or 1 Tablespoon sugar.
2. Retest in 15 minutes. Repeat treatment if blood sugar is still below 70 mg/dl.
3. If lunch or snack is more than 1 hour away, give one of the following 10 mins after juice:  
15 grams CHO                      7 grams of CHO

If student is unable to swallow or has lost consciousness, **CALL 911 AND** administer:

1. Glucagon Intramuscular Injection:              0.5mg              1 mg
2. Contact parent and nurse.

**Hyperglycemia**

1. If above 350 mg/dl, have the student wash hands and re-check blood sugar
2. If blood sugar still above 350, check urine for ketones
3. Give insulin for correction *if applicable*
4. Give extra water as tolerated
5. If ketones negative, trace or small AND without symptoms of illness, may resume normal activity
6. If ketones moderate or large and students feels ill, have Parent/Guardian pick up student
7. Notify Physician when urine ketones are moderate or large
8. Call 911 for any heavy breathing, severe vomiting, increased sleepiness or depressed level of consciousness

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**Parent Consent for Management of Diabetes at School**

I(we), the undersigned parent/guardian of the above-named student, request that the following specialized physical health care service for the Management of Diabetes in school be administered to my(our) child in accordance with Education Code Section 4942.5. I authorize the school nurse to communicate with the physician when necessary. I understand that I will be provided with a copy of my child's completed Individual School Healthcare Plan (ISHP). I will:

1. Provide the necessary supplies and equipment
2. Notify the school nurse if there is a change in student's health status or attending physician.
3. Notify the school nurse immediately and provide new consent for any changes in physician orders.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Physician Authorization for Management of Diabetes at School**

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented with Education Code Section 49423.5. I understand that specialized physical health care services may be performed by unlicensed, designated school personnel under the training and supervision by the school nurse.

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Received by School Nurse (Signature):** \_\_\_\_\_ **Date:** \_\_\_\_\_