



RYE CITY SCHOOL DISTRICT
Health Care Services
 Rye, NY 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.

<p>If Insulin At School: Brand Name and Type: _____</p> <p>Please notify the Following Personnel of my child's diabetes:</p> <p><input type="checkbox"/> All School Personnel <input type="checkbox"/> Cafeteria Personnel</p> <p><input type="checkbox"/> Only Personnel that have contact with my child</p> <p>Dose Preparation By:</p> <p><input type="checkbox"/> Pupil <input type="checkbox"/> Parent <input type="checkbox"/> Parent Designee <input type="checkbox"/> Licensed nurse</p> <p>Equipment Used:</p> <p><input type="checkbox"/> Syringe and vial <input type="checkbox"/> Insulin pen <input type="checkbox"/> Insulin pump</p> <p>Basal Rate _____ u/ml/hr.</p> <p>Insulin Bolus:</p> <p><input type="checkbox"/> Carb Counting: _____ # units per _____ gms Carbohydrate</p> <p><input type="checkbox"/> Morning snack <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon snack</p> <p>Insulin Administered by:</p> <p><input type="checkbox"/> Pupil <input type="checkbox"/> Parent <input type="checkbox"/> Parent Designee <input type="checkbox"/> Licensed Nurse</p> <p>(All parent designees are trained by the parent and are not employees of the school or district)</p> <p>Blood Glucose Testing:</p> <p><input type="checkbox"/> Before Meals <input type="checkbox"/> As Needed <input type="checkbox"/> By Pupil <input type="checkbox"/> 2 hours postprandial <input type="checkbox"/> Prior to exercise <input type="checkbox"/> Needs Assistance</p>	<p>Care of Hyperglycemia:</p> <p><input type="checkbox"/> 240 or above <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Check ketones if 240 or above as follows:</p> <p><input type="checkbox"/> By Pupil independently <input type="checkbox"/> Needs Assistance <input type="checkbox"/> Call if ketones in urine</p> <p>Care of Hypoglycemia when Below 70:</p> <p><input type="checkbox"/> Suspend pump if applicable <input type="checkbox"/> Self treatment of mild lows <input type="checkbox"/> Assistance for all lows <input type="checkbox"/> 3-4 glucose tablets (15 carb) <input type="checkbox"/> Glucagon injection for severe hypoglycemia:</p> <p style="padding-left: 20px;"><input type="checkbox"/> 0.5 mgm <input type="checkbox"/> 1 mgm</p> <p><input type="checkbox"/> Retest in 15 minutes <input type="checkbox"/> If <70 repeat fast acting carb <input type="checkbox"/> Retest in 15 minutes <input type="checkbox"/> Notify Physician when: _____ <input type="checkbox"/> Notify Parent When: _____ <input type="checkbox"/> Resume pump if blood sugar is >70.</p> <p>Student is to be tested where they are immediately if they are hypoglycemic.</p>
---	---

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 the above patient in the proper way to use his/her medications. It is my professional opinion that the patient should be allowed to carry and use that medication by him/herself. _____ Physician Initial

PHYSICIAN'S SIGNATURE: _____ **Date: (must be on/after July 1st):** _____

STAMP/LICENSE/PHONE/ADDRESS: _____

Reviewed by School Nurse (Signature) _____	Date: _____
---	--------------------