



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.

If Insulin At School: Brand Name and Type: _____

Please notify the Following Personnel of my child's diabetes:

- ☐ All School Personnel ☐ Cafeteria Personnel
☐ Only Personnel that have contact with my child

Dose Preparation By:

- ☐ Pupil
☐ Parent
☐ Parent Designee
☐ Licensed nurse

Equipment Used:

- ☐ Syringe and vial
☐ Insulin pen
☐ Insulin pump

Basal Rate _____ **u/ml/hr.**

Insulin Bolus:

- ☐ Carb Counting: _____ # units per _____ gms Carbohydrate
☐ Morning snack ☐ Lunch ☐ Afternoon snack

Insulin Administered by:

- ☐ Pupil ☐ Parent
☐ Parent Designee ☐ Licensed Nurse

(All parent designees are trained by the parent and are not employees of the school or district)

Blood Glucose Testing:

- ☐ Before Meals ☐ As Needed
☐ By Pupil ☐ 2 hours postprandial
☐ Prior to exercise ☐ Needs Assistance

Care of Hyperglycemia:

- ☐ 240 or above ☐ Other: _____
☐ Check ketones if 240 or above as follows:

- ☐ By Pupil independently
☐ Needs Assistance
☐ Call if ketones in urine

Care of Hypoglycemia when Below 70:

- ☐ Suspend pump if applicable
☐ Self treatment of mild lows
☐ Assistance for all lows
☐ 3-4 glucose tablets (15 carb)
☐ Glucagon injection for severe hypoglycemia:
 ☐ 0.5 mgm
 ☐ 1 mgm
☐ Retest in 15 minutes
☐ If <70 repeat fast acting carb
☐ Retest in 15 minutes
☐ Notify Physician when: _____
☐ Notify Parent When: _____
☐ Resume pump if blood sugar is >70.

Student is to be tested where they are immediately if they are hypoglycemic.

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:** _____