Please complete and return to the Health Clerk at school site

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

Pupil	**DOB**	**School**	**Grade**

Physician's Written Authorization: Please initial and check all boxes that apply.

1. Blood Glucose Testing: □ Before meals □As needed
□ By pupil □ Needs assistance

2. Routine Care of Hypoglycemia When Below 70:
□ Self treatment of mild lows □ Assistance for all lows
Notify physician when: _____

3. Emergency Care of Severe Hypoglycemia:
□ Glucose gel: □ Conscious □ Unconscious
□ Glucagon injection: □ 0.5 mgm □ 1 mgm
Notify physician when: _____

4. Care of Hyperglycemia:
□ 240 or above □ 300 or above □ Other: _____
□ Check ketones if 300 or above as follows:
□ By pupil independently □ Needs assistance

5. Insulin at school:
□ Not at this time
□ Lunchtime dose: use sliding scale
□ Correction lunchtime dose: use sliding scale
□ Carb Counting: _____#units per_____gms Carbohydrate
□ Morning Snack □ Lunch □ Afternoon snack

If Insulin at School: Brand Name and Type:
_____

Dose Preparation By:
□ Pupil independently
□ Parent
□ Parent designee
□ Licensed nurse

Equipment Used
□ Syringe and vial
□ Insulin pen
□ Insulin pump
□ Inhaler

# of SQ Insulin Units Determined By:
□ Pupil □ Licensed nurse

Written sliding scale as follows:
Blood Glucose from _____to_____=_____Units
Blood Glucose from _____to_____=_____Units
Blood Glucose from _____to_____=_____Units
Blood Glucose from _____to_____=_____Units

Insulin Administered by:
□ Pupil □ Parent
□ Parent designee □ Licensed nurse
□ Pupil with staff verification of Insulin Pen or Pump #.
(All parent designees are trained by the parent and are not employees of the school or district.)

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 the management of Diabetes in school be administered to our (my) child in accordance with Education Code Section 49423.5.
I will:

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 Healthcare Plan (ISHP.)

Parent/Guardian Signiture_____Date_____

Physician Authorization For Diabetes at School

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance 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 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.)

□ I have instructed _____in the proper way to use his/her medications. It is my professional opinion that
(Student's Name)
_____ should be allowed to carry and use that medication by him/herself. _____Physician Initial
(Student's Name)

□ I request that the School Nurse provide me with a copy of the completed Individualized School Healthcare Plan (ISHP.)

Physician Name _____Physician Signature _____Date_____

Phone _____ Address _____ City_____ Zip_____

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

Reviewed by Principal (Signature) _____ (Date) _____