

**Parent Consent and Physician Authorization
For Management of Diabetes at School**

Pupil _____ DOB _____ School _____ Grade _____

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

<p>Blood Glucose Testing: <input type="radio"/> Before meals <input type="radio"/> As needed <input type="radio"/> other _____ <input type="radio"/> By pupil <input type="radio"/> Needs assistance</p> <p>Routine Care of Hypoglycemia (below 70): <input type="radio"/> Self-treatment of mild lows <input type="radio"/> Assistance for all lows Notify physician when: _____</p> <p>Emergency Care of Severe Hypoglycemia: <input type="radio"/> Glucose gel: <input type="radio"/> Conscious <input type="radio"/> Unconscious <input type="radio"/> Glucagon injection: <input type="radio"/> 0.5 mgm <input type="radio"/> 1 mgm Notify physician when: _____</p> <p>Care of Hyperglycemia: <input type="radio"/> 240 or above <input type="radio"/> 300 or above <input type="radio"/> Other: _____ <input type="radio"/> Check ketones if _____ or above: <input type="radio"/> By pupil independently <input type="radio"/> Needs assistance</p> <p>Insulin at School: <input type="radio"/> Not at this time <input type="radio"/> Lunchtime dose: use sliding scale <input type="radio"/> Sliding scale dose at other times: _____ <input type="radio"/> Carb correction dose: <input type="radio"/> Morning snack <input type="radio"/> Lunch <input type="radio"/> Afternoon snack Carb Counting: ___# units/___gms CHO</p>	<p>If Insulin at School: Brand and Type: _____</p> <p>Dose Preparation By: Equipment Used: <input type="radio"/> Pupil <input type="radio"/> Syringe & vial <input type="radio"/> Parent <input type="radio"/> Insulin pen <input type="radio"/> Parent designee <input type="radio"/> Insulin pump <input type="radio"/> Licensed nurse</p> <p>Number of SQ Units Determined By: <input type="radio"/> Pupil <input type="radio"/> Licensed nurse</p> <p>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</p> <p>SQ Insulin Administered By: <input type="radio"/> Pupil <input type="radio"/> Parent <input type="radio"/> Parent designee <input type="radio"/> Licensed nurse <input type="radio"/> Pupil with staff verification of Pen or Pump #.</p> <p>(All parent designees are trained by the parent and are not employees of the school or district)</p>
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Other needs (specify): _____

Parent Consent for Management of Diabetes at School

We (I), the undersigned parent(s)/guardian(s) of the above named pupil, request that the following specialized health care service for 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's health status or attending physician.
3. Notify the school nurse immediately and provide new consent for any changes in MD orders.

Parent/Guardian signature _____ **Date** _____

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 in accordance with Ed Code sec. 49423.5. I understand that specialized 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. _____ **MD initial**
- It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself. _____ **MD**

Physician Name: _____ **Signature:** _____ **Date:** _____
Phone: _____ **Address:** _____ **City:** _____ **Zip:** _____

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