## 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

**Blood Glucose Testing:**
○ Before meals ○ As needed ○ other ____ _____
○ By pupil ○ Needs assistance

**Routine Care of Hypoglycemia (below 70):**
○ Self-treatment of mild lows
○ Assistance for all lows
Notify physician when: _____

**Emergency Care of Severe Hypoglycemia:**
○ Glucose gel: ○ Conscious ○ Unconscious
○ Glucagon injection: ○ 0.5 mgm ○ 1 mgm
Notify physician when: _____

**Care of Hyperglycemia:**
○ 240 or above
○ 300 or above
○ Other: _____
○ Check ketones if _____ or above:
○ By pupil independently ○ Needs assistance

**Insulin at School:** ○ Not at this time
○ Lunchtime dose: use sliding scale
○ Sliding scale dose at other times: _____
○ Carb correction dose: ○ Morning snack ○ Lunch
○ Afternoon snack
Carb Counting: ___# units/____gms CHO

**If Insulin at School: Brand and Type:**
_____

**Dose Preparation By:**
○ Pupil
○ Parent
○ Parent designee
○ Licensed nurse

**Equipment Used:**
○ Syringe & vial
○ Insulin pen
○ Insulin pump

**Number of SQ 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

**SQ Insulin Administered By:**
○ Pupil ○ Parent
○ Parent designee ○ Licensed nurse
○ Pupil with staff verification of Pen or Pump #.

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

**Other needs (specify):** _____

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### 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** _____

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### 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:** _____

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