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____ Self Tests ____ Supervised test ___
2. **Routine Care of Hypoglycemia When Below 70:**
____Self treatment of mild lows ___Assist for all lows
Notify Physician/Parent/ when______________

1. **Emergency Care of Severe Hypoglycemia:**
____Glucose gel: ____Conscious ___Unconscious
____Glucagon injection: ____0.5 mgm____1 mgm
Notify physician when:_____________________
2. **Care of Hyperglycemia:**
____ 240 or above ____300 or above ____Other:______
____Check ketones if 300 or above
Notify physician when:___________________
3. **Insulin at school:**
____ Not at this time
____Correction dose (see next column)
____ AM break ____Lunch
(see next column)

If Insulin At School: Brand Name and Type:
Equipment Used:
____Syringe and vial ____Insulin pump
____Insulin pen ____Other:________________________

Insulin Dose Determined By (Check all that apply):
_____Standard lunchtime ______ May Self Manage dose:________________________

____Insulin to Carbohydrate ratio:
- ____# unit(s) insulin per _____gms Carbohydrate

____Correction Calculation:
- Insulin Sensitivity Factor:____unit(s) insulin lowers blood glucose by ______mg/dl
- Target Blood Glucose________mg/dl

____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

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 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 Signature ____Date________

Print name:____

Physician Authorization for Management of 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 request that the School Nurse provide me with a copy of the completed Individualized School Healthcare Plan.(ISHP)

Physician Signature ____ Date ______________________

Address ___________________________________Phone number:________________________________
(Use Office stamp)

Reviewed by School Nurse (Signature________________Principal _____________Date _____________