PUPIL _____ **DOB** _____ **GRADE** _____ **SCHOOL** _____ **SCH YR** _____

Authorization for Management of Diabetes at School and School Sponsored Events

Individualized School Healthcare Plan (ISHP) and Standard Procedures Will Provide Details for Implementation

Physician's Written Authorization: Please fill in lines and check all boxes that apply

1. Authorized Health Care Provider Opinion on Student's Ability to Perform Procedures:

Student is competent and can self-perform the following procedures: (parent and school nurse must verify competency as well)

☐ Blood Glucose Testing ☐ Carry supplies for blood glucose monitoring ☐ Testing in classroom

☐ Self treatment for mild lows ☐ Independently operate insulin pump ☐ Measuring insulin

☐ Injecting insulin ☐ Carry supplies for insulin administration ☐ Injection in classroom

☐ Determining insulin dose ☐ Counts carbohydrates

Student needs assistance to perform the following procedures:

☐ Blood Glucose Testing ☐ Carry supplies for blood glucose monitoring ☐ Testing in classroom

☐ Self treatment for mild lows ☐ Independently operate insulin pump ☐ Measuring insulin

☐ Injecting insulin ☐ Carry supplies for insulin administration ☐ Injection in classroom

☐ Determining insulin dose ☐ Counts carbohydrates

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2. Blood Glucose Testing Orders

☐ **No blood glucose testing at school required at this time**

☐ **Blood Glucose Testing** (desired range _____mg/dl to _____ mg/dl) **for**:

☐ Before PE/exercise ☐ Before AM snack ☐ Before lunch ☐ 2 hours after lunch ☐ 2 hours after a correction dose

☐ For suspected hypo/hyperglycemia ☐ At student's discretion except always for suspected hypoglycemia

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3. Mild Hypoglycemia (☐ BG < 70 mg/dl or ☐ BG < _____ mg/dl)

Student must never be alone when hypoglycemia is suspected and should be treated on site. Give ☐ 15 gm or ☐ _____ gm fast-acting glucose and recheck in ☐ 15 minutes or ☐ _____ minutes. If still hypoglycemic, treat again with same dose of glucose and recheck at same interval until normal. Notify parent if not improved after 3 treatments.

☐ Provide extra protein and carb snack after treating lows if next meal/snack not scheduled for ☐ 1 hr ☐ 2 hr.
Call parent for symptoms of hypoglycemia, but BG is normal.

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4. Severe Hypoglycemia (seizure, unconscious, combative, unable to swallow). **Call 911; ensure open airway.**

☐ If conscious, use glucose gel inside cheek.

☐ If seizure or unconscious, give Glucagon injection IM. ☐ 0.5 mg ☐ 1 mg

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5. Hyperglycemia (intervention if BG greater than _____ mg/dl)

If thirsty or looks dry, provide water. If student is ill or vomiting, call parent to pick up student. For confusion, labored breathing or coma – **Call 911.**

☐ Call parent if BG > _____ mg/dl, or if ketones > _____

☐ If BG > _____ mg/dl, initiate insulin administration orders

☐ If BG > _____ mg/dl, check ketones.

- If ketones are trace/small, give water and no exercise.
- If ketones are mod/lg, call parent to pick up student.

Return to class if asymptomatic, doesn't meet above criteria, or if the above action items are not ordered.

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6. Illness

If student is ill, check blood glucose and ketones if ordered and strips provided.
If blood glucose and ketones are within range, follow standard procedures for an ill child and notify parent.

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7. Bus Transportation

☐ Blood glucose test not required prior to boarding bus

☐ Test blood glucose 10 to 20 minutes before boarding bus and treat as indicated.

☐ Additional special needs: _____

_____

8. Oral Diabetes Medication

☐ Oral Medication needed at school Medication _____ dose _____ time _____

_____

9. Insulin Orders

☐ **No insulin at school required at this time**

☐ **Insulin required at school:**

Insulin: ☐ Humalog ☐ Novolog ☐ Other: _____ Via: ☐ syringe ☐ pen ☐ pump

Food/bolus insulin dose (complete only those that are needed at school)

☐ Per pump setting

☐ Routine dose: _____ unit(s) time of this dose _____

☐ Insulin to carb ratio: _____ unit(s) insulin per _____ gm carbohydrate

Correction Dose (complete only those that apply):

☐ Per pump setting

☐ Give _____ unit(s) for every _____ mg/dl above _____ mg/dl ***OR***

☐ Sliding scale as follows: (Be specific in sliding scale).

Blood Glucose from _____ to _____ = _____ Units
Blood Glucose from _____ to _____ = _____ Units
Blood Glucose from _____ to _____ = _____ Units
Blood Glucose from _____ to _____ = _____ Units
Blood Glucose over _____ = _____ Units

Add food/bolus dose to correction dose: ☐ am snack ☐ lunch ☐ pm snack ☐ party/treats ☐ other

_____

_____

10. Meal Plan (timing will be routine school times unless otherwise indicated)

Content of meal/snack or carbohydrate count to be specified by: ☐ parent ☐ student ☐ health care provider (attach if needed).

☐ Breakfast	☐ mandatory	☐ at student's discretion _____
☐ AM snack	☐ mandatory	☐ at student's discretion _____
☐ Lunch	☐ mandatory	☐ at student's discretion _____
☐ PM snack	☐ mandatory	☐ at student's discretion _____

Extra food allowed at ☐ parent's ☐ student's discretion
(Teacher to notify parent(s) ahead of time for class parties, etc.)

_____

_____

11. Exercise

Liquid/solid carbohydrate sources must be available for all exercise.
Follow hypo/hyperglycemia protocols as indicated:
No exercise if blood sugar is less than _____ or greater than _____.
No exercise if ketones are greater than _____.

☐ Eat _____ grams of carbs for vigorous exercise: ☐ before ☐ every 30 minutes during ☐ after exercise

☐ Student may disconnect pump for up to _____ hour(s) or decrease basal rate at their discretion.

_____

_____

12. Other: _____

PUPIL **DOB** **GRADE** **SCHOOL** **SCH YR**

Parent Authorization for Management of Diabetes at School and School Sponsored Events

I, the undersigned, the parent/guardian of the above named pupil, request that the specialized physical healthcare service be performed for my child. I understand that the school administrator will appoint a qualified designated person(s) who, in accordance with Education Code 49414.5 and 49423.5, will perform the healthcare procedure listed above. My signature below verifies:

- I understand that whenever possible, the healthcare procedure must be provided before or after school hours.
- I will provide all the necessary supplies, equipment, medication(s) on an on-going basis throughout the school year.
- I will notify the school nurse if there is a change in my child's health status or physician.
- I will notify the school nurse immediately and provide new written consent/authorization for any changes therein.
- I authorize the school nurse to communicate with the health care provider when necessary.
- I understand that the school nurse will communicate with district school staff regarding my child's ISHP.
- I understand that I may request a copy of this completed ISHP.

Parent/Guardian Signature _____ **Date** _____

Parent/Guardian Authorization For Self-Administration/Self-Managing

I the undersigned, the parent/guardian of the above named pupil, confirm that my child has been instructed by his/her healthcare provider on the proper use of insulin and in self management of diabetes. He/She has demonstrated to me that he/she understands and is physically, mentally and behaviorally capable to assume this responsibility and in accordance with Educational code 49414.5 and 49423.5 will perform healthcare procedures as directed by the healthcare provider.

- I understand that whenever possible, the healthcare procedure will be performed before or after school hours.
- I will provide all the necessary supplies, equipment, medication(s) on an on-going basis throughout the school year.
- I will notify the school nurse if there is a change in my child's health status or physician.
- I will notify the school nurse immediately and provide new written consent/authorization for any changes therein.
- I permit my child to self medicate/self manage as ordered by his/her physician.
- If my child experiences urgent diabetic side effects, he/she will immediately report this to school staff.
- I understand that sharing medication with other students will result in disciplinary action.
- I release the school district and school personnel from civil liability if the pupil suffers any adverse reaction as a result of self-medicating/self-managing.
- I authorize the school nurse to communicate with the health care provider when necessary.
- I understand that the school nurse will communicate with district school staff regarding my child's ISHP.
- I understand that I may request a copy of this completed ISHP.

Parent Signature _____ **Date** _____

Physician Authorization for Management of Diabetes at School and School Sponsored Events

- I understand that the procedure(s) must be performed before or after school hours if at all possible.
- I understand that the individual performing the procedure may or may not be a licensed nurse. The school administrator may designate a school employee to perform services in accordance with Education Code 49423.5 and Business & Professions Code 2725(b)(2).

☐ _____ (please initial). This child has been instructed and understands the purpose, appropriate method/frequency of medication use, safety and standard precautions and is **competent in self-administering his/her medication/self-managing.**

My signature below provides authorization for the above.

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

This form must be renewed whenever there are changes and at least once a year.

Reviewed by School Nurse (signature) _____ (date) _____