Pupil: ________________________________ DOB: ______________________ Date: _______________

Parent Consent and Authorized Health Care Provider Authorization for Insulin Dose During a Disaster

Dose administered via ____prefilled syringe ____insulin pen ____syringe ____insulin pump

RECOMMENDATIONS

For students who do not carb count, if insulin is available but there is a limited food supply then consider decreasing the usual dose of NPH, Lente, Ultralente or Lantus by 25%. Regular or rapid-acting insulins may not be needed. Initial space below if in agreement:

____ If there is a limited food supply, decrease dose of long acting insulin by 25% and do not use short acting insulin.

Usual daily insulin regimen (decrease the following doses if limited food supply):

Insulin Brand Name and Type(s):____

	Time of Day	Units of NPH, Lente, or Ultralene or Lantus		Units of Regular, Humalog or Novolog	
		↓ 20-30%	↓10%	Omit	↓25%
Breakfast					
Lunch					
Dinner					
Bedtime					

____ For students who are on pumps, carb count, and/or use multiple injections use the following calculations with (circle one) Regular Humalog Novolog

____ Insulin to carbohydrate ratio:

•__________#unit(s) insulin per __________gms Carbohydrate

____Correction calculation (complete only those that supply):

•Give _______unit(s) for every _______mg/dl abo ve _______mg/dl

•Decrease correction by _____% unit(s) if PE or increased activity is anticipated after dose, or last dose was given less than 2 hours befor e

OR

____ 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

____Add carb calculation insulin dose and correction calculation for total insulin dose/bolus

AUTHORIZED HEALTH CARE PROVIDER AUTHORIZATION

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state law governing school health services. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

Authorized Health Care Provider Signature: ________________________________Date: ______________

Address: ________________________________ City ____________________ Zip ___________
(Use office stamp)
Phone Number ___________________________

PARENT OR GUARDIAN CONSENT

We(I), the undersigned, the parent(s)/guardian of the above named pupil, request that the above defined insulin doses be given during a disaster for our (my) child in accordance with California Education Code 49423.5.

Parent/guardian Signature: ____ Date: ____________

Reviewed by School Nurse (signature): _____________________________________ Date: ____________

Reviewed by Principal (signature): _______________________________________ Date: ____________

Note: Completion of this form is for disaster purposes only. Failure to complete this form does not give reason for school exclusion.