

Parent Consent and Authorized Health Care Provider ISHP Authorization For Management of Diabetes at School and School Sponsored Events

Pupil: _____ **DOB:** _____ **School:** _____ **Grade:** _____

Authorized Health Care Provider's Written Authorization: Please fill in lines and check all boxes that apply.

1. **Authorized Health Care Provider Opinion on Student's Competence with Procedures:** Student 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 Measuring insulin
 Injecting insulin Injection in classroom Determining insulin dose
 Independently operate insulin pump Carry supplies for insulin administration

2. **Blood Glucose Testing** (desired range _____mg/dl to _____mg/dl)
 Before am snack Before lunch 2 hours after lunch
 2 hours after a correction dose For suspected hypoglycemia
 At student's discretion except always for suspected hypoglycemia
 No blood glucose testing at school required at this time

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 & 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

4. **Severe Hypoglycemia** (seizure, unconscious, combative, unable to swallow)
 Call 9-1-1; ensure open airway
 OK to use glucose gel inside cheek if conscious
 Glucagon injection IM 0.5 mg 1 mg, if seizure or unconscious

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 strongly consider pickup. For confusion, labored breathing or coma – call 9-1-1
 Call parent if BG > _____mg/dl, or if ketones _____ or larger.
 If BG > _____mg/dl initiate insulin administration orders
 If BG > _____mg/dl, check ketones in urine blood
 Return to class if asymptomatic, doesn't meet above criteria, or if the above action items are not ordered.

6. **Illness**
 If student is ill, check ketones and blood glucose if provided.
 If ketones are _____ or greater, provide fluids, call parents, and consider pickup.
 If ketones and blood glucose are within range, follow standard procedures for an ill child and notify parent.

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

8. **Insulin Orders** (complete only if insulin is needed at school):
 Brand name of insulin: _____
 Routine administration times (fill in times for all those that apply):
 Breakfast AM snack Lunch Other _____
 Insulin administration via:
 Syringe pump pen Other _____
Food/bolus insulin dose (complete only those that apply):
 Insulin to carb ratio: ___ unit(s) insulin per _____ gm carbohydrate or
 routine breakfast dose _____ unit(s) (if given at school)
 routine AM snack dose _____ unit(s)
 routine lunch dose _____ unit(s)
 routine other dose _____ unit(s) (time of this dose _____)
Correction Dose (complete only those that apply):
 Give _____ unit(s) for every _____mg/dl above _____mg/dl
 Sliding scale as follows:
 Blood Glucose from _____ to _____ = _____ Units
 Blood Glucose from _____ to _____ = _____ Units
 Blood Glucose from _____ to _____ = _____ Units
 Blood Glucose from _____ to _____ = _____ Units
 Blood Glucose from _____ to _____ = _____ Units
 OK to add food/bolus dose to correction dose

9. **Meal Plan**
 Meal/snack will be considered mandatory unless student's discretion also checked. Attach orders for breakfast or PM snacks are if needed. Timing will be routine school times unless indicated. Content of meal/snack to be specified by
 parent, student, or health care provider (attach if needed).
 AM snack At student's discretion special time: _____
 Lunch At student's discretion special time: _____

10. **Exercise** (complete only if needed):
 Liquid/solid carb sources must be available for all exercise.
 Follow hypoglycemia, illness, and hyperglycemia protocols when relevant.
 Eat _____ extra 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

11. **Other Needs:** Specify on prescription pad or letterhead and attach.

The signatures below provide authorization for the above written orders and show agreement that all procedures must be implemented in accordance with state laws and regulations. This authorization is for a maximum of one year. If changes are indicated, new written authorization or a signed addendum to this form will be needed.

The school nurse will provide the health care provider and the parent/guardian with a copy of this form after all signatures are obtained. A copy of the entire ISHP is also available on request to the health care provider or parent/guardian.

Authorized Health Care Provider Name: _____ Signature _____

Address _____ City _____ State _____ Zip _____

Date: _____ Phone: _____

Parent(s)/Guardian(s) Signature _____ Date _____

School Nurse Signature _____ Date _____

Principal or designee Signature _____ Date _____