

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 above ___ 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 before

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 State laws and regulations.

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.