FOR PUMPERS

Parent Consent and Healthcare Provider Authorization
For Management of Diabetes at School and School Sponsored Events

Student Information School District: _____

Student's Name: _____ DOB: _____School: _____Gr:_____

□ Type 1 Diabetes □ Type 2 Diabetes

Routine Management: Target Blood Sugar Range for School _____to_____

Required Blood Sugar Testing At School:

□ Trained personnel must perform blood sugar test
□ Trained personnel must supervise blood sugar test
□ Student can perform testing independently w/o supervision
□ Please provide parent w/BS #'s weekly
□ Before AM snack
□ Before lunch
□ For suspected hypoglycemia
□ At student's discretion
□ Other times _____

Student's Competency:

□ Student may carry supplies for BG monitoring
□ Student may test in classroom
□ Student may carry supplies for insulin administration
□ Student may determine insulin dose □ with or □ without supervision
□ Student may inject insulin □ with or □ without supervision
□ Student may measure insulin □ with or □ without supervision
□ Student may operate insulin pump independently
□ Student must be supervised for pump therapy
□ RN must operate insulin pump supervision

Note: Supervision could be the RN or whom she has designated.

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.

Examples of 15 grams of fast acting glucose: 3 glucose tablets; 2 packages of "Smarties"; 4 oz of regular juice; 4 oz of regular soda

- □ Give □15 grams or □ _____ grams of fast acting glucose and recheck in 10-15 minutes
- □ If still hypoglycemic, treat again with same dose of glucose and recheck at same interval until normal. NOTE: IF STILL HYPOGLYCEMIC AFTER 3 TX, NOTIFY PARENTS.
- □ Once blood sugar is above 70 mg/dl or _____mg/dl, provide 15 grams extra carbohydrate and protein snack (i.e. peanut butter and crackers or cheese and crackers) if next meal is not scheduled for 1 hour

Moderate Hypoglycemia: If student is conscious but *unable* to effectively drink fluids offered:

- □ Administer 15 grams of glucose gel between cheek and gum with head elevated. Encourage student to swallow. NOTIFY PARENTS.
- □ Recheck in 10 minutes.
- □ If still hypoglycemic repeat above.
- □ Once blood sugar is above 70 mg/dl or _____mg/dl, provide 15 grams extra carbohydrate and protein snack (i.e. peanut butter and crackers or cheese and crackers) if next meal is not scheduled for 1 hour

Severe Hypoglycemia: Seizure, unconscious, combative, or unable to swallow

1. Call 911 and ensure open airway

□ Give Glucagon Injection IM □ 0.5 mg □ 1.0 mg □ N/A _____ per parent request
Parent Initial

Hyperglycemia: Intervene if BS is > _____ mg/dl and provide extra water

- □ If BS is > 300 mg/dl, check □ urine □ blood for ketones
- □ Call parent if any ketones are present

❖ If child has no ketone test strips at school, BS > 300 mg/dl and child is feeling ill, call for pick up. If child is feeling okay: 1) Encourage water, 2) Follow correction scale as indicated under "Insulin Orders", and 3) Notify parents that ketone test strips need to be brought to school.
❖ If no ketones present, send back to class or regular routine with extra water. Okay to do exercise
❖ Do not allow exercise if any ketones are present

Original to Parent □ _____

Date □ Faxed or □ Mailed _____ Fax #:_____ **Revised 5/09**

Facility RN Initial _____

FOR PUMPERS

(*Continuation of Healthcare Provider Authorization*)

Student Name: _____
DOB: _____

Bus Transportation/Field Trips:
□ Always take meter and treatment for lows □ Blood glucose test not required prior to boarding bus
□ Test blood sugar 10-20 minutes before boarding bus and treat as indicated

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Insulin Pump Orders:

Brand Name of Insulin: _____
Insulin times at school: □ Breakfast □ AM snack □ Lunch □ Other _____

Insulin administered via pump:

Insulin dose: AM snack □ Insulin to carbohydrate ratio: ____unit insulin for every _____grams of carbohydrate

Lunch □ Insulin to carbohydrate ratio: ____unit insulin for every _____grams of carbohydrate

Correction dose: □ Give ____unit insulin for every _____mg/dl above ____mg/dl

□ O.K. to add correction to routine insulin dose

Meal Plan:
□ Student needs assistance with counting carbohydrates
□ Student is independent with counting carbohydrates
□ Parents will send food from home with carbohydrates labeled

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Disaster Plan:
*Emergency personnel may give insulin if RN is not present

□ On Pump Therapy

Authorized Health Care Provider Authorization for Management of Diabetes at School

My signature below provides authorization for the above written order, including administration of Glucagon . I understand that all procedures will be implemented in accordance with state laws and regulations. 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)

Physician Signature _____ **Date** _____

Address _____ City, St Zip _____ Phone ( ) _____ Fax: ( ) _____

Parent Consent for Management of Diabetes at School

I (We), the parent/guardian of the above named student request that the following for Management of Diabetes in school be administered to our child in accordance with state laws and regulations.

I will:
1. **Provide the necessary supplies and equipment**
2. **Notify the school nurse if there is a change in the student health status or change of 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 Authorized Health Care Provider when necessary. I understand that I will be provided a copy of my child's completed Individual School Healthcare Plan (ISHP)

Parent Signature: _____ Date_____

School Nurse Signature: _____ Date_____ **Revised 5/09**

Facility RN Initial _____