NIAGARA FALLS CITY SCHOOL DISTRICT
Health Services

PARENT CONSENT AND HEALTH CARE PROVIDER AUTHORIZATION FOR MANAGEMENT OF DIABETES AT SCHOOL AND SCHOOL SPONSORED EVENTS

Individual School Health Care Plan and Standard Procedures will provide details for implementation

Student:_____ DOB:_____ Grade:_____.

Health Care Provider Written Authorization: Please Initial and check all boxes that apply

If insulin at school: Type of Insulin_____

Please notify the following personnel of my child's diabetes:
□ all school personnel □ Cafeteria personnel
□ only personnel that has contact with my child

Dose preparation by:
□ student
□ parent
□ parent designee
□ licensed nurses

Equipment used:
□ syringe and vial
□ insulin pen
□ insulin pump

Basal rate: to be updated by parent

Insulin Bolus:
□ carb counting:_____ #unit per_____ gms carbohydrate
□morning snack □ lunch □ afternoon snack

Correction Factor: 1 unit of Humalog/Novolog _____mg/dl
Decreases in blood glucose level > 120/150

Insulin administered by:
□ student □ parent
□ parent designee □ licensed nurse
(All parent designees are trained by the parent and are not employees of the school or district)

Blood glucose testing:
□ before meals □ as needed
□ by pupil □ 2 hours postprandial
□ prior to exercise if longer than one hour □ needs assistance
Other_____

Care of hyperglycemia:

□ **240 or above** □ **Other:** _____
□ check ketones if 240 or above as follows:
□ by student independently
□ needs assistance
If ketones in urine, contact: □ parent/guardian
□ Diabetes Center @ 878-7262 □ health care provider

Care of hypoglycemia when below 70:
□ suspend pump if applicable
□ assistance for all lows
□ 3-4 glucose tablets (15 carbs)
□ glucagon injection for severe hypoglycemia:
□ 0.5 mgm
□ 1.0 mgm
□ retest in 15 minutes
□ if < 70, repeat fast acting carb
□ retest in 15 minutes
□ notify health care provider when: _____
or
□ resume pump if blood sugar is > 70

Student is to be tested where they are immediately if they are hypoglycemic.

*** REQUIRED: SLIDING SCALE**: **COVERAGE**

BG_____--_____ _____UNITS _____ insulin

BG_____--_____ _____UNITS_____ insulin

BG_____--_____ _____UNITS _____insulin
(attach additional form if needed)

Parent Consent for Management of Diabetes at School

We (I), the undersigned, and the parent(s)/guardian(s) of the above named student, request that the following specialized Physical Health Care Service for Management of Diabetes in School be administered to our (my) child. I will provide:

1. necessary supplies and equipment;
2. notification to the school nurse if there is a change in the students health status; AND
3. notification to the school nurse immediately and provide new consent for any changes in health care provider orders.

I consider my child a well controlled, self–directed diabetic that should be allowed to carry and use his/her medications. Yes_____ No _____
I authorize the school nurse to communicate with the health care provider when necessary. I understand that I will be provided a copy of my Child's completed Individual School Health Care Plan.

Parent /Guardian Signature Date

Health Care Provider Authorization for Diabetes Management in School

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented. I understand that unlicensed, designated school personnel , under training and supervision by the school nurse, may perform specialized physical health care services. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

□ I have instructed _____in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and use his/her medication.
□ This student is a well controlled, self-directed diabetic and may participate in gym and Interscholastic Sports without restrictions.

Physician signature Stamp Date

Reviewed by School Nurse (Signature)_____ Date_____ F27 – 5/10