**Parent Consent and Physician Authorization**
**For Management of Diabetes at School and School Sponsored Events**

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

**To be completed by Physician: Please initial and check all boxes that apply**

**Blood Glucose Testing:**
☐As needed ☐Before meals ☐By pupil ☐Needs Assistance

**Routine Care of Hypoglycemia when below 70 (See attached standard protocol)**
☐Self treatment of mild lows ☐Assistance for all lows per attached protocol- Additional instructions:

**Emergency Care of Severe Hypoglycemia: (See attached standard protocol)**
☐Glucose gel ☐Glucagon injection - ☐0.5 mgm ☐1 mgm

**Care of Hyperglycemia: (See attached standard protocol)**
☐240 or above ☐300 or above ☐Other _____
☐Check ketones if 300 or above as follows:

**Insulin at School:**
☐Not at this time
☐Student able to self administer insulin, performing appropriate dose calculations
☐Carb Counting: _____# units per _____gms Carbohydrate. **Insulin Type**_____

**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

☐**Student can self-manage diabetes on overnight field trips**

**List Any Concerns About Transporting the Student on the School Bus:**

**Parent Consent for Management of Diabetes at School**
We(I), the undersigned, the parent/guardian of the above named pupil, request that the following specialized physical health care service for Management of Diabetes in school be administered to our (my) child in accordance with Education Code Section 49423.5. I will:

1. Notify the school nurse if there is a change in pupil health status or attending physician
2. Notify the school nurse immediately and provide new consent for any changes is doctor's orders.
3. I authorize the school nurse to communicate with the physician when necessary.
4. I understand that I will be provided a copy of my child's completed Emergency Health Care Plan.

**Parent/Guardian Signature** _____ **Date** _____

**Physician Authorization for Management of Diabetes at School**
My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with Education Code Section 49423.5. I understand that specialized physical health care services, i.e. blood sugar testing, may be preformed 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** _____ **Zip** _____

**Received by School Nurse (Signature )** _____ **Date** _____