Authorization and Consent for School Diabetes Management

WOODFORD COUNTY SCHOOLS

Student: _____ Date of Birth: _____ Date:_____

School: _____ Grade: _____ Social Security #: _____

AUTHORIZED HEALTH CARE PROVIDER WRITTEN AUTHORIZATION.
PLEASE CHECK ALL THE BLANKS THAT APPLY BELOW.

1. **Blood Glucose Monitoring**

□ Before breakfast □ Before AM snack □ Before lunch □ Before PM snack

□ As needed for suspected hypoglycemia □ Other: _____

***Target range for blood glucose at school: _____**

2. **Hypoglycemia for blood sugar less than _____**

□ Provide extra protein & carbohydrate snack: _____

□ Use glucose gel or cake icing inside cheek if conscious

□ Glucagon IM injection for severe hypoglycemia and unresponsiveness

□ Other:_____

3. **Hyperglycemia for blood sugar greater than _____**

□ No exercise if glucose is greater than _____

□ For blood glucose greater than _____ administer insulin per Physician or APRN's written order

□ Check urine ketones if blood glucose is above _____

□ Other: _____

4. **Student may self-administer the following per school protocol with parent and school nurse verification of student competency:**

□ Blood glucose testing □ Insulin measurement and injection □ Calculation of insulin dose

□ Independent operation of insulin pump □ Other: _____

5. **Insulin Orders**

Brand name and type: _____

Insulin dose administered via:

□ Pre-filled syringe □ Insulin pen □ Syringe □ Insulin pump

*** If student self-administration is not possible, only a school nurse will administer insulin according to written orders.**

6. **Insulin Administration Time(s)- make notation if <u>before</u> or <u>after</u> food intake.**

□ Breakfast □ AM snack □ Lunch □ PM Snack

□ Other: _____

□ Insulin to carbohydrate ratio: _____ # unit(s) of insulin per _____ grams of Carbohydrate

7. **Determination of Insulin Dose (Check all that apply)**

□ Standard lunchtime dose: _____

□ Correction Calculation

□ Give _____ unit(s) of Insulin for every _____ mg/dl above ____ mg/dl

OR

□ Written sliding scale as follows:

Blood Glucose from_____ to _____= _____Units of Insulin

Blood Glucose from_____ to _____= _____Units of Insulin

Blood Glucose from_____ to _____= _____Units of Insulin

Blood Glucose from_____ to _____= _____Units of Insulin

□ Additional Instructions: ____

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Additional orders or concerns should be provided on a prescription or Authorized Health Care Provider stationary with the Physician or APRN signature. Please attach additional forms to these sheets.

The written orders above will be implemented in accordance with Kentucky laws and regulations. Designated unlicensed school staff under the training and supervision of the school nurse may perform delegated student health care services. This written order will expire after the current school year ends. Any changes to the order will need to be provided in writing by the Authorized Health Care Provider on an original Woodford County Schools authorization form.

Physician or APRN Signature: _____

Please print Physician or APRN Name: _____

Date: _____ Phone: _____ Address: _____

PARENTAL CONSENT FOR STUDENT DIABETES MANAGEMENT AT SCHOOL

As the parent(s)/guardian(s) of _____, I (We) agree with the above written orders, provided by the Authorized Health Care Provider, for Diabetes management during school. I (We) understand that the health services will be provided in accordance with Kentucky laws and regulations. Unlicensed designated school staff under the training and supervision of the school nurse will provide some services. I (We) will provide the supplies and equipment needed for proper management of care. I (We) will notify the school nurse(s) if there is any change in the student's health status and provide new written orders from the Authorized Health Care Provider. I (We) authorize the school nurse(s) to communicate with the Authorized Health Care Provider and school staff as deemed necessary for proper school management of care.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____

Reviewed by Principal: _____ Date: _____

Review/Revised:1/2/07