PHYSICIAN AUTHORIZATION FORM

A MILE IN MY SHOES

PARENT CONSENT AND PHYSICIAN AUTHORIZATION FOR MANAGEMENT OF DIABETES IN SCHOOL

Pupil:	DOB:	School:	Grade:
Physician's Written Authorization: Please circle all items & check all boxes that apply to above mentioned pupil:			

1. Blood Glucose Testing:
   ☐ Before Meals ☐ As needed ☐ By pupil ☐ Needs assistance

2. Routine care of Hypoglycemia when below _____:
   ☐ Self treatment of mild lows ☐ Assistance for all lows
   ☐ Notify (parent/physician/nurse) when blood sugar below: _____

3. Emergency care of severe Hypoglycemia:
   ☐ Glucose gel, honey if conscious ☐ Glucagon injection: 0.5mg (1/2 vial) 1mgm (whole vial)
   ☐ Call 911 if unconscious

4. Care of Hyperglycemia:
   ☐ _____ or above ☐ Check ketones if above _____
   ☐ By pupil independently ☐ By pupil with supervision

5. Insulin at school:
   ☐ Not at this time ☐ Lunchtime dose: *use sliding scale* ☐ Correction (lunchtime) dose: *use sliding scale*
   ☐ Call parent/MD for dose if unsure how to apply sliding scale

6. Snack(s): *(or equivalent substitute)*
   Morning snack: _____ Afternoon snack: _____

If insulin at school: Name and Type (Rapid, intermediate acting) _____

Dose Preparation by:
☐ Pupil, independent ☐ Pupil, assisted ☐ Pupil, supervised ☐ Parent
☐ School nurse ☐ School personnel

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Equipment Used:

☐ Syringe & Vial ☐ Insulin Pen ☐ Insulin Pump

# of SQ units to be administered, as per sliding scale:

Blood glucose from _____ to _____ = _____ units

Blood glucose from _____ to _____ = _____ units

Blood glucose from _____ to _____ = _____ units

Blood glucose from _____ to _____ = _____ units

SQ dose administered by:

☐ Pupil, independent ☐ Pupil, assisted ☐ Pupil, supervised ☐ Parent

☐ School nurse ☐ School personnel

(All doses MUST be verified by a trained adult and/or School nurse)

Parent Consent for Management of Diabetes in School

We(I), the undersigned, the parent(s)/guardian(s) 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(ren) in accordance with Education Code Section 49423.5.

I will:

1. Provide the necessary supplies & equipment.
2. Notify the school nurse if there is a change in pupil health status or attending physician.
3. Notify the school nurse immediately & provide new consent for any changes in doctor's orders
4. Revise/renew this request on a yearly basis, with the start of each new school year.

I authorize the school nurse/personnel to communicate with the physician when necessary.

I understand that I will be provided with a copy of my child's Individual School Healthcare Plan (ISHP).

Parent/Guardian Signature:_____ Date:_____

Physician Authorization for Management of Diabetes in School

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with Education Code 49423.5. 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)

☐ *I request that the School Nurse provide me with a copy of the completed Individual School Healthcare Plan (ISHP).*

Parent/Guardian Signature: _____ Date: _____

Address: _____ City: _____ Zip Code: _____

Reviewed by School Principal (signature):_____

Date:_____