Guadalupe Union School District PHYSICIAN AUTHORIZATION FOR HEALTH CARE SERVICES AT SCHOOL

(Page 1 of 2)

## **Student Information**

		STUDEN	NT'S NAME	:			DATE OF	BIRTH		
	AL CONDITION:	🖵 Diabe				□Sec	ondary Diab	etes		
PATIEN	IT IS CAPABLE C					<b>.</b>	<i>(</i> <b>2</b> )			
		ielf-Manag	gement (Ind	), USelf-Ma	nagement with	Supervision	(Supv), or 🗆	l I otal Ci	are (Total) for the followin	ng:
Blood G	ducose resting:	u ina.			Give insuli	n by injection:		Ind.	□ Supv. □ Total □ Supv. □ Total	
Carbony	vorate counting.	u ina.	Supv. u		Give insuli	i by insulin pl	ump.	lina.		
	Blucose Monitori									
	range of blood gl						00-200	Other		
	lood glucose with					t at school.				
	endent, student m				•	tested before	a lunah anal i	farbibit	ing signalay matama of hi	~~~~~
	od glucose. Stude						e lunch and l	rexhibit	ing signs/symptoms of hi	gn or
	before snacks				fter exercise		etting on bus		□Other	
							stung on bus			
	<u>ycemia (Treatme</u>									
	Treatment is give					raada 2 alu	aaaa tablata	15 aron	no aluonoo aol	
Ζ.	Treat with one of 1 tablet sugar in		nng. 4 oz. a	iny time of ju	ice, 4 oz regula	ar soua, s giu	cose lablels,	is gran	ns giucose gei,	
3.	Retest in 15 min		anaat stan	2 if blood s	ugar is still be	Now 70 Also	ronoat ston	2 if sym	ntoms persist	
4.	If lunch or snack									
	□ 15 gram CHO							]		
	□ 7-8 gram CH0									
5.									s to lose consciousness,	is
	•					ow blood gluc	ose event ar	nd it is a	medical emergency.	
•	Glucagon can be					<b>6</b> 1.				
6.	•	•	•	for students	under 10 year	s of age and '	1 mg = 1 cc i	f ten yea	ars or older. If it is not	
	possible to give g				occ avant th	a naront and	school nur	o chou	ld be informed.	
				-		-				
	<u>lycemia</u> – Treatm									
1	(Check urine for k	atonas 11	o not allow	student to e	xercise it ketor	es are preser	nt. Encourage	e water.		
2.	Insulin correction	can be g	iven: 🛛 befo	ore AM snac	k 🛛 🛛 before lu	inch 🛛 Oth	er:			
2. 3.	Insulin correction Do not give corre	can be g	iven: Dbefo e frequently	ore AM snac than every	k □before lu □2-3 hours □	inch <sup>`</sup> ⊒Oth IOther:	er:			
2.	Insulin correction	can be g	iven: Dbefo e frequently	ore AM snac than every	k □before lu □2-3 hours □	inch <sup>`</sup> ⊒Oth IOther:	er:		□Apidra	
2. 3.	Insulin correction Do not give corre	can be g	iven: Dbefo e frequently	ore AM snac than every ed and give	k □before lu □2-3 hours □	inch <sup>`</sup> ⊒Oth IOther:	er:			
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2. 3.	Insulin correction Do not give correc Insulin for correc BG 150-200 BG 201-250 BG 251-300	can be g ction mor tion OR <u>a</u>	iven: □befo e frequently s determin	ore AM snac v than every ed and give BG 40 BG 40 BG 50	k	inch ⊡Oth IOther: <b>⊐Humalog</b>	er:			
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2. 3. 4. <u>Student</u>	Insulin correction Do not give correc Insulin for correc BG 150-200 BG 201-250 BG 251-300 BG 301-350 BG 351-400 Parent or school n ts on Fixed Regin Student is on a fi	urse to not net net net net net net net net net ne	iven: □befo e frequently s determine ify provider if plan with th	e following a	k □before lu □2-3 hours □ <u>n by parent:</u> 01-450 51-500 01-550 51-Hi high BG mount of carbonack	Inch Oth Other: DHumalog	er: <b>Diver:</b> Other: O) during scl	<b>&gt;g</b>  nool:		
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2. 3. 4. <u>Student</u>	Insulin correction Do not give correction Insulin for correction BG 150-200 BG 201-250 BG 251-300 BG 301-350 BG 351-400 Parent or school n ts on Fixed Regin Student is on a fit AM snack Insulin therapy hours and give ts on Basal Bolus On this regime, Type of basal ins Type of bolus ins Insulin/carbohyde	a can be g ection mor tion OR <u>a</u> urse to not <u>ne</u> I N/A xed meal in case o insulin to in case o insulin: IN students sulin: IN rate ratio: in case o	iven: Dbefore frequently s determine ify provider if plan with th Lunchr additional f disaster: sing scale i Regime with need to ta do Novolog	e following a carbohydrat For all stud in hyperglyd h Multiple [ ke insulin e bse: units per or students	k Defore It D2-3 hours D <u>n by parent:</u> 01-450 51-500 51-50 51-Hi imount of carbonack es: ui ents other that cemia #4; keep Daily Injection very time carl grams C on MDI: Chec	Inch Oth IOther: Humalog Humalog hydrate (CH hits per n those on a child from child from s (MDI) DN/A ohydrates a (Usuall HO. Correction k blood gluo	er: Novolo Novolo Other: Other: Other: other: grams n insulin scl re eaten! y taken at ho on insulin: sc cose every 4		□Apidra eck blood glucose ever dosis. en by parent) glycemia and give correction	y 4

Guadalupe Union School District PHYSICIAN AUTHORIZATION FOR HEALTH CARE SERVICES AT SCHOOL

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STUDENT'S NAME:	DATE OF BIRTH:			
Students with Insulin Pumps				
(Technical support: call pump company number on back of pu				
Basal rates can change often. These can be reviewed in the p				
Insulin/carbohydrates ratio: One unit of insulin will cover				
Correction/Sensitivity factor: one unit of insulin will decrease bl				
Insulin therapy in case of disaster for students on pump: I	Alaintain basal rates as above with meal and corrections			
boluses as needed.	ware even the under and sive connection according to the			
If unable to administer insulin by the pump check blood gl Correction protocol above in addition to insulin for carbor				
Exercise and Sports	iyurales.			
The student may participate in sports:Image: YesImage: NoActivity restrictions:Image: NoneImage: Other:Image: Image: Other:				
Fast-acting carbohydrate should be readily available at all time	s for low blood glucose symptoms.			
Student should not exercise if urine ketones are present or if b				
Bus Transportation				
Blood glucose test not required prior t boarding bus.				
Test blood glucose 10 – 20 minutes before boarding bus.				
<ul> <li>Provide 15 gm glucose source if blood glucose is</li> </ul>				
Provide care as follows:				
Other:     Supplies to be Kent at Selecel				
Supplies to be Kept at School A blood glucose meter and strips along with back-up insulin (vi	al with syringes or pen) should be available for all students			
Other items that may be brought in by parents include urine ke	•••			
containing snacks, Glucagon emergency kit and back-up insuli				
Other Instructions:				
Authorized Health Care Provider Authorizatio My signature below provides authorization for the above written orders. I understand that regulations. I understand that specialized physical health care services may be perform provided by the school nurse. This authorization is for a maximum of one year. If change Authorized Health Care Provider:	at all procedures will be implemented in accordance with state laws and ed by unlicensed designated school personnel under the training and supervision			
Signature: Date:	Stamp Physician Name/Address Below:			
Phone: Fax:				
I have instructed in the proper way to use his/her medication It is my professional opinion that should be allowed to carry a				
medication by him/herself. (Child's Name)				
Authorized Healthcare P				
I request that the School Nurse provide me with a copy of the completed Individualiz	zed School Healthcare Plan (ISHP)			
Parent Consent for Manageme				
Parent Consent for Management           I (We), the undersigned, the parent(s)/guardian(s) of the above named pupil, request the administered to my (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 pupil health status or attended.           3. Notify the school nurse immediately and provide new consent for any change in authorize the school nurse to communicate with the Authorized Healthcare Provider we completed Individual School Healthcare Plan (ISHP).	at the above written orders for Management of Diabetes in school be ting Authorized Health Care Provider inges in doctor's orders.			
<ul> <li>I (We), the undersigned, the parent(s)/guardian(s) of the above named pupil, request the administered to my (our) child in accordance with state laws and regulations.</li> <li>I will: <ol> <li>Provide the necessary supplies and equipment.</li> <li>Notify the school nurse if there is a change in pupil health status or attend</li> <li>Notify the school nurse immediately and provide new consent for any change I authorize the school nurse to communicate with the Authorized Healthcare Provider w</li> </ol> </li> </ul>	at the above written orders for Management of Diabetes in school be ling Authorized Health Care Provider inges in doctor's orders. hen necessary. I understand that I will be provided a copy of my child's			
<ul> <li>I (We), the undersigned, the parent(s)/guardian(s) of the above named pupil, request the administered to my (our) child in accordance with state laws and regulations.</li> <li>I will: <ol> <li>Provide the necessary supplies and equipment.</li> <li>Notify the school nurse if there is a change in pupil health status or attend</li> <li>Notify the school nurse immediately and provide new consent for any cha</li> </ol> </li> <li>I authorize the school nurse to communicate with the Authorized Healthcare Provider w completed Individual School Healthcare Plan (ISHP).</li> </ul>	at the above written orders for Management of Diabetes in school be ding Authorized Health Care Provider inges in doctor's orders. hen necessary. I understand that I will be provided a copy of my child's Date:			
I (We), the undersigned, the parent(s)/guardian(s) of the above named pupil, request the administered to my (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 pupil health status or attend 3. Notify the school nurse immediately and provide new consent for any cha I authorize the school nurse to communicate with the Authorized Healthcare Provider w completed Individual School Healthcare Plan (ISHP). Parent/Guardian Signature: Parent/Guardian Signature: Self Administration:	at the above written orders for Management of Diabetes in school be ding Authorized Health Care Provider inges in doctor's orders. hen necessary. I understand that I will be provided a copy of my child's Date:			
I (We), the undersigned, the parent(s)/guardian(s) of the above named pupil, request the administered to my (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 pupil health status or attend 3. Notify the school nurse immediately and provide new consent for any chance is a change in the Authorize the school nurse to communicate with the Authorized Healthcare Provider we completed Individual School Healthcare Plan (ISHP). Parent/Guardian Signature: Parent/Guardian Signature: I request that my child be allowed to carry/self-administer his/her medication.	at the above written orders for Management of Diabetes in school be ding Authorized Health Care Provider inges in doctor's orders. hen necessary. I understand that I will be provided a copy of my child's Date:			
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I (We), the undersigned, the parent(s)/guardian(s) of the above named pupil, request the administered to my (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 pupil health status or attend 3. Notify the school nurse immediately and provide new consent for any chance and individual School Healthcare Plan (ISHP). Parent/Guardian Signature: Parent/Guardian Signature: Self Administration: I request that my child be allowed to carry/self-administer his/her medication. I request that my child be allowed to self-perform blood glucose testing. I agree to and do hereby hold the District and its officers, agents, employees and/or volu damages, expenses, or loss of any sort, including bodily injury or death, because of or a self administer of the section.	at the above written orders for Management of Diabetes in school be ting Authorized Health Care Provider inges in doctor's orders. hen necessary. I understand that I will be provided a copy of my child's Date: Date: unteers harmless for any and all claims, demands, causes of actions, liability,			
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