Guadalupe Union School District

PHYSICIAN AUTHORIZATION FOR HEALTH CARE SERVICES AT SCHOOL

Student Information

STUDENT'S NAME: _________________________________ DATE OF BIRTH:___________

PHYSICAL CONDITION: ❑ Diabetes Type 1 ❑Diabetes Type 2 ❑Secondary Diabetes

PATIENT IS CAPABLE OF:

❑Independent Self-Management (Ind), ❑Self-Management with Supervision (Supv), or ❑Total Care (Total) for the following:

Blood Glucose Testing: ❑ Ind. ❑ Supv. ❑ Total Give insulin by injection: ❑ Ind. ❑ Supv. ❑ Total

Carbohydrate counting: ❑ Ind. ❑ Supv. ❑ Total Give insulin by insulin pump: ❑ Ind. ❑ Supv. ❑ Total

Blood Glucose Monitoring

Target range of blood glucose: ❑70-100 ❑70-120 ❑70-150 ❑70-180 ❑100-200 ❑ Other

Check blood glucose with meter brought from home or additional meter left at school.

If Independent, student may carry meter and test as necessary.

If Supervised or Total Care is required, student should have blood glucose tested before lunch and if exhibiting signs/symptoms of high or low blood glucose. Student should also be checked at the following times:

❑ before snacks ❑before exercise ❑after exercise ❑before getting on bus ❑Other

Hypoglycemia (Treatment of low blood glucose)

1. Treatment is given for low blood glucose less thant 70 mg/dl.
2. Treat with one of the following: 4 oz. any time of juice, 4 oz regular soda, 3 glucose tablets, 15 grams glucose gel, 1 tablet sugar in water.
3. Retest in 15 minutes and **repeat step 2 if blood sugar is still below 70**. Also, repeat step 2 if symptoms persist.
4. If lunch or snack is more than one hour away give one of the following 15 minutes after the juice:
   ❑ 15 gram CHO choice per parent or student & protein
   ❑ 7-8 gram CHO choice per parent or student & protein
5. Whenever possible the school nurse or trained personnel should administer glucagon if child begins to lose consciousness, is having a seizure or is unable to swallow. This is called a severe low blood glucose event and it is a medical emergency. Glucagon can be given subcutaneously or IM in the arm or thigh.
6. Dosage of Glucagon is 0.5 mg = ½ cc for students under 10 years of age and 1 mg = 1 cc if ten years or older. If it is not possible to give glucagon, call 911.

After treatment for a severe low blood glucose event, the parent and school nurse should be informed.

Hyperglycemia – Treatment if blood glucose >❑300 or ❑ other:__________ ❑See Insulin Pump section

1. Check urine for ketones. Do not allow student to exercise if ketones are present. Encourage water.
2. Insulin correction can be given: ❑before AM snack ❑before lunch ❑Other: ______________________
3. Do not give correction more frequently than every ❑2-3 hours ❑Other:_____________________________
4. Insulin for correction OR **as determined and given by parent:** **❑Humalog ❑Novolog ❑Apidra**

BG 150-200__________________________ BG 401-450__________________________
BG 201-250__________________________ BG 451-500__________________________
BG 251-300__________________________ BG 501-550__________________________
BG 301-350__________________________ BG 551-Hi __________________________
BG 351-400__________________________

Parent or school nurse to notify provider if low BG<________ high BG>_________ Other: _______

Students on Fixed Regime ❑ N/A

❑ Student is on a fixed meal plan with the following amount of carbohydrate (CHO) during school:
AM snack ______ Lunch ______ PM snack ______

❑ Student can take insulin for additional carbohydrates: _______ units per _________grams CHO

Insulin therapy in case of disaster: For all students other than those on an insulin pump, check blood glucose every 4 hours and give insulin using scale in hyperglycemia #4; keep child from developing ketoacidosis.

Students on Basal Bolus Insulin Regime with Multiple Daily Injections (MDI) ❑N/A

On this regime, students need to take insulin every time carbohydrates are eaten!

Type of basal insulin:__________ dose:__________ time:_________(Usually taken at home/given by parent)

Type of bolus insulin: ❑Novolog ❑Humalog

Insulin/carbohydrate ratio: _________ units per _______grams CHO. Correction insulin: scc Hyperglycemia

Insulin therapy in case of disaster for students on MDI: Check blood glucose every 4 hours and give correction according to the hyperglycemia protocol (#4-sliding scale) in addition to insulin for carbohydrates.

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Students with Insulin Pumps ❑ N/A

(Technical support: call pump company number on back of pump. Call provider for clinical support)

Basal rates can change often. These can be reviewed in the pump or written down by parents.

Insulin/carbohydrates ratio: One unit of insulin will cover ____ grams CHO

Correction/Sensitivity factor: one unit of insulin will decrease blood glucose ______________mg/dL

Insulin therapy in case of disaster for students on pump: Maintain basal rates as above with meal and corrections boluses as needed.

If unable to administer insulin by the pump check blood glucose every 4 hours and give correction according to the Correction protocol above in addition to insulin for carbohydrates.

Exercise and Sports

The student may participate in sports: ❑ Yes ❑ No

Activity restrictions: ❑ None ❑ Other: ____

Fast-acting carbohydrate should be readily available at all times for low blood glucose symptoms.

Student should not exercise if urine ketones are present or if blood glucose is less than 70 mg/dL.

Bus Transportation

❑ Blood glucose test not required prior t boarding bus.

❑ Test blood glucose 10 – 20 minutes before boarding bus.

- Provide 15 gm glucose source if blood glucose is < ______mg/dL
- Provide care as follows: ____
- Other:____

Supplies to be Kept at School

A blood glucose meter and strips along with back-up insulin (vial with syringes or pen) should be available for all students. Other items that may be brought in by parents include urine ketone strips, fast-acting source of glucose, carbohydrate containing snacks, Glucagon emergency kit and back-up insulin pump supplies.

Other Instructions: ____

Authorized Health Care Provider 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 state laws and regulations. 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).

Authorized Health Care Provider:

Signature: ____**Date:** ______________________

Phone: ___________________________________ **Fax:** ________________________________

Stamp Physician Name/Address Below:

___I have instructed ____________________in the proper way to use his/her medications.
It is my professional opinion that _____________________ should be allowed to carry and use that medication by him/herself. (Child's Name)

_____Authorized Healthcare Provider Initials

___I request that the School Nurse provide me with a copy of the completed Individualized School Healthcare Plan (ISHP)

Parent Consent for Management of Diabetes at School

I (We), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the above written orders for Management of Diabetes in school be 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 attending Authorized Health Care Provider
3. Notify the school nurse immediately and provide new consent for any changes in doctor's orders.

I authorize the school nurse to communicate with the Authorized Healthcare Provider when necessary. I understand that I will be provided a copy of my child's completed Individual School Healthcare Plan (ISHP).

Parent/Guardian Signature: _____________________________________ Date: ______________________

Parent/Guardian Signature: _____________________________________ Date: ______________________

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 volunteers harmless for any and all claims, demands, causes of actions, liability, damages, expenses, or loss of any sort, including bodily injury or death, because of or arising out of acts of omissions with respect to the administration of the medication(s).

Parent/Guardian Signature: ____ Print Name:_________________________________ Date:_________________