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

Highland Park Independent School District

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

Physician's Written Authorization: Please initial and check all boxes that apply

1. **Blood Glucose Testing:** ☐ Before meals ☐ As needed ☐ By pupil ☐ Needs assistance
2. **Routine Care of Hypoglycemia When Below 70:**
   ☐ Self treatment of mild lows ☐ Assistance for all lows
   Notify when:_____
3. **Emergency Care of Severe Hypoglycemia:**
   ☐ Glucose gel: ☐ Conscious ☐ Unconscious
   ☐ Glucagon injection: ☐ 0.5 mgm ☐ 1 mgm
   Notify : when:_____
4. **Care of Hyperglycemia:**
   ☐ 240 or above ☐ 300 or above ☐ Other:_____
   ☐ Check ketones if 300 or above as follows:
   ☐ By pupil independently ☐ Needs assistance
5. **Insulin at school:**
   ☐ Not at this time
   ☐ Lunchtime dose: use sliding scale
   ☐ Correction lunchtime dose: use sliding scale
   ☐ Carb Counting:____# units per _____gms Carbohydrate
   _____ ☐ Morning snack ☐ Lunch ☐ Afternoon snack

If Insulin At School: Brand Name and Type:
_____

Dose Preparation By:	**Equipment Used**
☐ Pupil	☐ Syringe and vial
☐ Parent	☐ Insulin pen
☐ Parent designee	☐ Insulin pump
☐ Licensed nurse	☐ Inhaler

# of SQ Insulin Units Determined By:
☐ Pupil ☐ Licensed nurse

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

SQ Insulin Administered By:
☐ Pupil ☐ Parent
☐ Parent designee ☐ Licensed nurse
☐ Pupil with staff verification of Insulin Pen or Pump #.

(All parent designees are trained by the parent and are not employees of the school or district)

Other Needs (Specify):

Parent Consent for Management of Diabetes at 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 :

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 physician
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 physician when necessary.

Parent/Guardian Signature _____ **Date** _____

Physician Authorization For Diabetes Management In School

My signature below provides authorization for the above written orders. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed)

☐ 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. _____Physician Initial

Physician Name_____ **Physician Signature** _____ **Date** _____

Phone _____ **Address** _____ **City** _____ **Zip** _____

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