Hilliard City Schools
Diabetes Management at School
Health Care Provider Authorization and Parent/Guardian Consent

The purpose of this form is to aid the school nurse in gathering the information necessary to develop the student's Individualized Health Plan (IHP) and Emergency Care Plan. ***It must be completed by the student's health care provider*** *and reviewed by the parent/guardian. Both parties' signatures are required on page 3.*

Student's Name: _____ Date of Birth: _____

Grade: _____ Known Allergies: _____

Diagnosis: _____ Type 1 Diabetes _____ Type 2 Diabetes Date of Diagnosis: _____

Blood Glucose Monitoring

Target Range for glucose level is _____mg/dl to _____mg/dl

Should not exercise if glucose is <_____mg/dl or >_____mg/dl or if ketones are present

Time(s) for routine glucose check: _____

Additional tests needed if/when: _____

Can student perform his/her own glucose checks? Yes or No (To be verified with parent and nurse)
Exceptions: _____

Glucose checks are routinely performed in the school clinic unless the health care provider deems an alternative site necessary. Specialized health care services may be designated to unlicensed school personnel under the training and supervision of the school nurse.

Medication Authorization for Insulin

By law, the following are required before the nurse or designee may dispense medication to a student.

1. Medication order, completed and signed by the licensed prescriber
2. Parent/guardian authorization with signature
3. Medication in the original container with pharmacy label to match the prescriber's order

Type and dose of insulin to be taken at school: _____ Route: _____ Time: _____
Type and dose of insulin to be taken at school: _____ Route: _____ Time: _____

If glucose is running high, I authorize an increase in the prescribed dosage by adding _____units for every _____ mg/dl over _____mg/dl

Possible Adverse Reactions: _____
Special/Storage Instructions: _____

Can student give his/her own injections? Yes or No
Can student determine correct dose of insulin? Yes or No
Can student draw correct dose of insulin? Yes or No

Beginning Date: _____ Ending Date: _____

Insulin Pump Information

Type of pump: _____ Basal rates: _____ 12:oo am to _____
_____ ____ __ to _____
_____ ____ __ to _____

Type of insulin in pump: _____ Type of infusion set: _____

Insulin to carbohydrate ratio: _____ Correction factor: _____

Is student competent/independent with pump use and maintenance? Yes or No (Parent and nurse to verify)
Can student effectively trouble shoot problems such as ketosis or pump malfunction? Yes or No

Comments:

Hypoglycemia

Usual symptoms of hypoglycemia: _____

Treatment of hypoglycemia: _____
_____
_____
_____

Has glucagon ever been administered? Yes or No
Does the student require a regular daily snack? Yes or No If yes, what and when?_____

Medication Authorization for Glucagon

Medication: _____ Dose: _____ Route: _____

Indications for Use: _____ Possible Adverse Reactions: _____

Special/ Storage Instructions: _____

Beginning Date:_____ Ending Date: _____

Hyperglycemia

Usual symptoms of hyperglycemia: _____

Urine should be tested for ketones when blood glucose levels are above: _____mg/dl

Treatment of hyperglycemia: _____

Health Care Provider Authorization

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 unlicensed designated school personnel under the training and supervision provided by the school nurse may perform specialized physical health care services. This authorization is valid for the duration of the current school year. If changes are indicated in the meantime, I will provide new written authorization.

Authorized Health Care Provider's Name: _____ **Phone:** _____

Provider's Address: _____

Signature: _____ **Date**: _____

NPI#_____ **Approved Ohio ORP: YES/NO**

Parent/Guardian Authorization

My signature below acknowledges that I have reviewed and agree to the health care provider's orders as outlined in this document. I understand that unlicensed designated school personnel under the training and supervision provided by the school nurse may perform specialized health care services. I understand that I am responsible for providing all supplies and equipment necessary for the care of my child at school. I understand that our health care provider must authorize any potential changes to my child's plan of care in writing.

I hereby give my permission for the above named student to receive and consume the medication(s) as directed in this document. I assume responsibility for the safe delivery of medication to school. I agree to notify the school immediately if there is any change in the medication order(s) and understand that school personnel may confirm such change(s) with my child's health care provider via telephone, fax or in writing. I understand that it is my child's responsibility to come to the office to receive the medication. I understand that no person authorized by the Board of Education to administer medication will be liable for administering or failing to administer unless such person acts in a manner constituting negligence or wanton/reckless misconduct.

Signature of Parent/Guardian: _____ **Relationship to Student**: _____

Date: _____ **Home Phone**: _____ **Work Phone**: _____ **Cell**: _____