DIABETIC MANAGEMENT PLAN

Parent Consent and Physician Authorization

Solana Beach School District
HEALTH SERVICES
309 N. Rios
Solana Beach, CA 92075

Dear Parent/Guardian and Physician of _____

California Education Code, Section: 49423.5 allows specialized health care services such as a Diabetes Management Plan to be performed by trained designated school staff under indirect supervision of a Credentialed School Nurse.

Diabetic management at school is provided only after the parent and physician complete specific instructions for the current school year.

1. Please complete and sign the attached Diabetic Management Plan and return to the Health Technician at your child's school.
2. All supplies are provided by the parent/guardian. Please notify the District Nurse of change in student health and/or change to physician's orders.
3. Parents may instruct their child in insulin dosage changes provided the child is self-administering insulin. If a licensed nurse is administering insulin, physician orders are required.
4. Parent may provide a three-day supply of food/insulin to be kept at school in case of emergency/disaster. Please complete Parent and Physician Authorization for insulin dose during disaster, <u>including</u> parent and physician signature.

Thank you for your assistance. Please call your District Nurse if you have questions.

I request that this Specialized Physical Health Care service for Management of Diabetes be administered to my child and authorization be given to the District Nurse to communicate with the physician when necessary. I also understand that if my child requires nursing support with insulin administration, a SBSD or contracted agency nurse will be available.

PARENT/GUARDIAN SIGNATURE_____ Date _____

Expiration date:
Glucagon: _____
Glucose Gel: _____

Physician Authorization

For Management of Diabetes at School and School Sponsored Events

Name:	DOB:	School:	Grade:
Mother	Home#	Work#	Alt.#
Father	Home#	Work#	Alt.#

PHYSICIAN'S WRITTEN AUTHORIZATION: PLEASE CHECK ALL THAT APPLY

1. Blood Glucose testing:
☐Before Meals ☐ As needed
☐By student independently ☐Needs Assistance/Monitoring
☐Adult verifies results

2. Snacks:
☐None ☐Before exercise
☐Morning ☐After exercise
☐Afternoon ☐Independent
☐Needs verification

3. Treat low blood sugar below as follows:
☐Standardized algorithm attached
☐Modified

4. Emergency care of severe hypoglycemia (low blood sugar)
Glucose gel per standardized procedure:
☐Conscious ☐Unconscious
Glucagon Injection per procedure **when unconscious**:
☐0.5 mg. ☐1 mg.

5. Treat high blood sugar above as follows:
☐Standardized algorithm attached
☐Modified
☐Check Ketones if blood sugar greater than _____

6. If Insulin needed at school:
Type of Insulin: _____
Insulin delivery by:
☐Insulin pen ☐Insulin pump
☐Insulin and syringes ☐Inhaler
☐Pre-filled syringes (labeled per dose)
Give Insulin at:
☐Lunch ☐As needed
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

Carbohydrate Counting:
☐Yes ☐No
_____# units per _____gms carb

Number of SQ Insulin Units Determined by:
☐Student ☐Licensed nurse
☐Parent ☐Parent Designee*

SQ Insulin Dose Prepared and Administered by:
☐Student ☐Parent/Parent Designee*
☐Licensed nurse: SBSD nurse/Agency nurse
☐Student with staff verification of dose (insulin pen, pump, or pre-filled syringe labeled with dose)
NOTE: Parent is not allowed to verbally change orders with the licensed nurse/school staff or give orders to their child unless the child is self-administering insulin.

The Health Technician must be Notified Two Weeks Before the Field Trip/Other Activity to plan for Qualified Personnel to Provide Procedure

7. Field Trip:
All diabetic supplies are taken and care is provided according to this Diabetic Plan (a copy is taken on trip). Student will have Blood Glucose checked ***before*** departing campus. If 70 or less, care will be provided per Procedure For Mild to Moderate Low Blood Glucose; parent will be called if not resolved.

8. Classroom/School party, food will be handled as follows:
☐Student will eat the treat
☐Replace with parent supplied alternative
☐Put in baggie and take home

9. Physical Education/Exercise:
☐None if Blood Glucose test results are:
below _____mg/dl
or
above _____mb/dl

* A parent designee is authorized by the parent and is not an employee of the school district.

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.

It is my professional opinion that this student be allowed to carry and administer such medications by himself/herself. _____ (PHYSICIAN INITIALS)

PHYSICIAN SIGNATURE_____ **DATE** _____

CA Medical License #:_____

PHONE #_____ **FAX #** _____