☐No ☐Yes Special Education?
☐No ☐Yes 504?

Parental Authorization for Diabetic Care

School Year: Campus:

Student	DOB	Grade/Homeroom	Transportation: ☐ Rides bus # _____ ☐ Car rider ☐ Walker

☐ Diabetes Type 1 ☐ Diabetes Type 2	Age diagnosed	In the past 3 months, has your child been treated for severe low or high blood sugar in the emergency room? ☐ Yes ☐ No

Physician	Phone	Fax

Meals and Snacks at School Plans for School (check all that apply): ☐ Bringing lunch from home ☐ Cafeteria

Is student independent in carbohydrate calculations and management? ☐ Yes ☐ No

Blood Glucose Monitoring: Type of meter: ☐ Yes ☐ No **Continuous Glucose Meter:**	Can student perform own blood sugar checks? ☐ Yes ☐ Yes, with assistance ☐ No
Insulin administration: ☐pen ☐Syringe ☐Pump (type)_____ ☐ None- ☐ Takes oral medication_____ ☐ Yes ☐ No My child has been a picky eater so insulin administration is either delayed until right after the meal or only a percentage is given before a meal per Dr. orders	Can student perform own insulin administration? ☐ Yes ☐ Yes, with assistance ☐No

HYPOGLYCEMIA (Low Blood Sugar): Usual symptoms are sweating, intense hunger, trembling, weakness, palpitations; often trouble speaking. Describe your child's usual symptoms for low blood sugar:	Does your child recognize these low blood sugar symptoms? ☐ Yes ☐ No ☐ Sometimes What blood sugar level is considered low for your child? _____ How often does your child typically experience low blood sugar? ☐ Daily ☐ Weekly☐ Monthly What time of day does your child typically experience low blood sugar? Is student independent in treatment of low blood sugar as prescribed by Dr. (i.e., taking quick acting sugar, re-checking): ☐ Yes ☐ No
HYPERGLYCEMIA (High Blood Sugar): Usual symptoms are frequently hungry, urinating and thirsty; fatigue, difficulty concentrating, blurred vision. Describe your child's usual symptoms for high blood sugar:	Does your child recognize these high blood sugar symptoms? ☐ Yes ☐ No ☐ Sometimes What blood sugar level is considered high for your child? _____ How often does your child typically experience high blood sugar? ☐ Daily ☐ Weekly ☐ Monthly What time of day does your child typically experience high blood sugar? _____ Is student independent in treatment of high blood sugar as prescribed by Dr. (i.e., checks ketones, gives insulin, water intake): ☐ Yes ☐ No

School management:

- Preferred location for diabetes care at school: ☐ School clinic with nurse ☐ Classroom/cafeteria/ "wherever the student is"
- Location of supplies at school: School clinic ☐ Student carries ☐ Student carries with extra supplies in school clinic

Please check all appropriate boxes below:

☐ Yes Agreement for Services: I authorize an unlicensed diabetes care assistant (UDCA) to provide diabetes management and care services as defined in the physician's orders and the student's Diabetes Care Plan. I understand that the UDCA is immune from liability for civil damages under section 22.0511 of the Texas Education Code. The UDCA can perform the following procedures for my child **(please initial the tasks that the UDCA can perform)**.

_____Check blood glucose with glucometer/CGM _____Administer quick acting sugar _____Give Glucagon

_____Check ketones _____Give insulin

☐ No I do not authorize an UDCA to provide diabetes management and care services to my child at school. I understand the school nurse, if available, or EMS, will provide emergency care as needed.

☐ Yes My child can manage his/her diabetes independently and will not seek assistance for his/her diabetes while at school. I understand the school nurse, if available, or EMS, will provide emergency care as needed. I understand the school nurse may temporarily supervise this responsibility if the student cannot demonstrate safe diabetes care while at school.

☐ Yes I request that my child's classmates be informed that my child has diabetes, and given age- appropriate instruction regarding diabetes care.

☐ Yes I authorize reciprocal release of information related to diabetes between the school nurse and my student's health care provider.

Student Agreement:

- ☐ I will always dispose of needles and sharps in an appropriate container (Not the trash can)
- ☐ I will notify the nurse if my symptoms, low or high, are not better after appropriate treatment
- ☐ I will notify a school employee if I should contaminate any surface with blood
- ☐ NA (student is not independent)

Student Signature: _____ Date: _____

Parent Signature	Best emergency phone	Other phone	Date
Emergency Contact	Phone	Other phone	

☐No ☐Yes Special Education?
☐No ☐Yes 504?

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Back Side for RN Use Only

Observes:

Yes	No/NA	
☐	☐	Identifies signs and symptoms and treatment of hypoglycemia
☐	☐	Identifies signs and symptoms and treatment of hyperglycemia
☐	☐	Demonstrates correct use of blood glucose meter
☐	☐	Demonstrates correct use of continuous blood glucose meter
☐	☐	Verbally appropriate response to blood glucose results/ interprets sliding scale use
☐	☐	Demonstrate correct use of ketones testing and treatment indicated
☐	☐	Demonstrates ability to count carbohydrates correctly for meals/snacks
☐	☐	Demonstrates correct insulin preparation
☐	☐	Demonstrates correct insulin administration per ☐ syringe ☐ pen ☐ pump

Initial appropriate boxes:

Demonstrate insulin pump skills: ☐ enter carbs ☐ enter blood sugar ☐ respond to alarms ☐ suspend ☐ remove /connect ☐ site insertion

Nurse Signature	Date

Nurse plan of care notes: