



The District School Board of Collier County Authorization/Physician's Order for Diabetes Care/Treatment

This form provides professional and parental authorization for medical treatment to be provided during school hours. Both the prescribing physician or health care provider and the parent/legal guardian are required to complete the respective sections of this document entirely before the services can be provided.

Student's Name _____ Sex _____ Date of Birth _____ Student # _____

School _____ Fax Number _____

Note: Physician's orders are required for all medical procedures and prescription medications administered at school. Please have your child's physician complete this portion of the form and return it or fax it to the school nurse. **It is the parent and/or physician's responsibility to notify the school if and when these orders change.**

The following section is to be completed by the prescribing physician or health care provider:

The student named in this document is under my medical supervision. I have prescribed the care/treatment that is necessary to be given during school hours for the child's health or safety. I am also aware that prescribed care or treatments may be administered by trained diabetes personnel.

BLOOD GLUCOSE MONITORING

To be performed by student? <input type="checkbox"/> Yes <input type="checkbox"/> No Location for testing: <input type="checkbox"/> Clinic/Health Room <input type="checkbox"/> Classroom <input type="checkbox"/> Other _____	Time, frequency of testing during school hours: <input type="checkbox"/> Lunch <input type="checkbox"/> PRN symptoms of hypoglycemia/hyperglycemia
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INSULIN ADMINISTRATION

Student requires the ROUTINE administration of _____ type of insulin. Route: <input type="checkbox"/> Pen <input type="checkbox"/> Pump <input type="checkbox"/> Injection Frequency: <input type="checkbox"/> Lunch <input type="checkbox"/> PRN per physician verbal order <input type="checkbox"/> Other _____ Insulin/Carbohydrate Ratio: _____	Please indicate which activities the student may perform without assistance: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Can student perform blood glucose monitoring?</td> <td style="padding: 2px;"><input type="checkbox"/> Yes</td> <td style="padding: 2px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 2px;">Can student perform urine ketone testing when indicated?</td> <td style="padding: 2px;"><input type="checkbox"/> Yes</td> <td style="padding: 2px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 2px;">Can student administer own insulin via prescribed route?</td> <td style="padding: 2px;"><input type="checkbox"/> Yes</td> <td style="padding: 2px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 2px;">Can student determine correct amount of insulin?</td> <td style="padding: 2px;"><input type="checkbox"/> Yes</td> <td style="padding: 2px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 2px;">Can student draw-up correct amount of insulin?</td> <td style="padding: 2px;"><input type="checkbox"/> Yes</td> <td style="padding: 2px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 2px;"> </td> <td> </td> <td> </td> </tr> <tr> <td style="padding: 2px;">Student is authorized to self-carry glucometer/supplies</td> <td style="padding: 2px;"><input type="checkbox"/> Yes</td> <td style="padding: 2px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 2px;">Student is authorized to self-carry and administer insulin</td> <td style="padding: 2px;"><input type="checkbox"/> Yes</td> <td style="padding: 2px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 2px;">Student may self-carry fast-acting glucose snacks</td> <td style="padding: 2px;"><input type="checkbox"/> Yes</td> <td style="padding: 2px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 2px;">Student may self-carry glucagon</td> <td style="padding: 2px;"><input type="checkbox"/> Yes</td> <td style="padding: 2px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 2px;"> </td> <td> </td> <td> </td> </tr> <tr> <td style="padding: 2px;">Parents are authorized to adjust insulin dosage* (See Below)</td> <td style="padding: 2px;"><input type="checkbox"/> Yes</td> <td style="padding: 2px;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 2px;">Parent may adjust insulin/carb ratio* (See Below)</td> <td style="padding: 2px;"><input type="checkbox"/> Yes</td> <td style="padding: 2px;"><input type="checkbox"/> No</td> </tr> </table>	Can student perform blood glucose monitoring?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Can student perform urine ketone testing when indicated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Can student administer own insulin via prescribed route?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Can student determine correct amount of insulin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Can student draw-up correct amount of insulin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				Student is authorized to self-carry glucometer/supplies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Student is authorized to self-carry and administer insulin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Student may self-carry fast-acting glucose snacks	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Student may self-carry glucagon	<input type="checkbox"/> Yes	<input type="checkbox"/> No				Parents are authorized to adjust insulin dosage* (See Below)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parent may adjust insulin/carb ratio* (See Below)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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FOR SLIDING SCALE INSULIN

High BG Levels	For BG levels: Between _____ - _____ Between _____ - _____ Between _____ - _____ Between _____ - _____ Between _____ - _____ Between _____ - _____ Between _____ - _____ Between _____ - _____	Sliding Scale Insulin # Units _____ Type _____ # Units _____ Type _____ # Units _____ Type _____ # Units _____ Type _____ # Units _____ Type _____ # Units _____ Type _____ # Units _____ Type _____ # Units _____ Type _____	High BG Levels: ≥ _____ <input type="checkbox"/> Check ketones <input type="checkbox"/> Call physician & parent if mod.- large ketones <input type="checkbox"/> Other _____
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Low BG levels: If BG is below _____, take the following actions:

Give 15 gm. of fast-acting glucose/gel/tabs. Recheck in 15 minutes. If <80, give additional 15 grams of fast-acting glucose and recheck in 15 minutes. If >80, and not lunchtime, give 15 grams of complex carbs (crackers, granola bar)

If >80 at lunchtime, send to lunch

GLUCAGON ADMINISTRATION

<input type="checkbox"/> I have prescribed injectable Glucagon for this student	Dosage: _____	Frequency: _____
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*The District reserves the right, based upon review by the nurse on site, to first consult with the physician before proceeding with any adjustments as indicated above. If an authorized parental adjustment appears to the nurse to be reasonable, the nurse may proceed with administration or contact the physician for further guidance in the child's best interest.

Please see other side-

Student name: _____ Student ID# _____

Physician's Name (Print): _____		Phone Number: _____	
Physician's Signature: _____		Date: _____	Fax Number: _____
Physician's Address: _____			
<input type="checkbox"/> Physician's Verbal Order Obtained: Date: _____ Time: _____			
Content of physician's verbal order obtained: _____			
Nurse's Signature: _____		Date: _____	Fax Number: _____

Parent/Legal Guardian Permission

The following section is to be completed by the parent/legal guardian:

I hereby grant permission to the principal or his/her designee of _____ school to assist in the administration of the care/treatment prescribed in this order to my child while in school and away from school while participating in official school activities (F.S. 1006.062). **It is my responsibility to notify the school if and when these orders change. A New written Authorization for Diabetes Care/Treatment will be needed.** I understand that the law provides there shall be no liability for civil damages as a result of the administration of such care/treatment where the person administering such care/treatment acts as an ordinarily prudent person would under the same or similar circumstances. If my child is authorized to carry diabetic supplies or equipment, I indemnify the school district, county health department and any public-private partner, and the employees and volunteers of those organizations, from any and all liability with respect to my child's use of such supplies and equipment.

1. I hereby give permission for my child's doctor or other authorized health care practitioner to be contacted for information regarding my child's illness, health or medical condition that may require nursing care or treatment during the school day or while participating in school related activities.
2. I hereby authorize the school nurse or trained diabetes personnel to perform nursing care or treatments that may be prescribed by my child's physician or authorized health care provider for the school day or while my child is participating in school related activities, including administration of glucagon.
3. I understand that I am responsible for providing the equipment, supplies and/or prescribed medications to the school that are required to perform these services for my child during the school day or while away from the school on school related activities.
4. I hereby agree to provide the equipment, supplies and/or prescribed medications for my child either on a daily basis or other schedule as prearranged with school staff members.
5. I understand that all medications, treatments, materials and supplies not picked up the last day of school will be properly disposed.
6. This Authorization is effective as of the date it is received at the child's school and it supersedes all previous authorizations or orders. This Authorization shall remain in effect until changed by the physician.
7. This Authorization must be renewed annually.

My child has:		<input type="checkbox"/> No allergies, <input type="checkbox"/> The following allergies:		
Parent/Guardian Name:				Relationship:
Home Phone:		Business Phone:		Emergency Phone:
Parent/Guardian Signature:				Date: