Maryville R-II School District
Parent Consent and Physician Authorization
For Management of Diabetes at School and School Sponsored Events

Student Name: ______________________ DOB: ____________ Grade: ________

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

Insulin At School:

Brand Name and Dose: ________________

Blood Glucose Testing

- ☐ Before Meals ☐ By Student
- ☐ As Needed ☐ Needs Assistance
- ☐ 2 hours Postprandial
- ☐ Prior to exercise

Insulin Bolus

- ☐ Carb Counting:_____ # units per gm
  - ____ Morning snack
  - ____ Lunch
  - ____ Afternoon Snack

Dose Preparation By:

- ☐ Student ☐ Parent Designee
- ☐ Parent ☐ Licensed Nurse

Equipment Used:

- ☐ Syringe and Vial
- ☐ Insulin Pen
- ☐ Insulin Pump

Basal Rate: ____________**u/ml/hr**

Insulin Administered By:

- ☐ Student ☐ Parent Designee
- ☐ Parent ☐ Licensed Nurse

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

Care of Hyperglycemia:

- ☐ 240 or above ☐ Other: ________
- ☐ Check Ketones if 240 or above as follows
  - ☐ By student independently
  - ☐ Needs Assistance
  - ☐ Call if ketones are in urine

Care of Hypoglycemia

- ☐ Suspend pump if applicalble
- ☐ Self-treatment of mild lows
- ☐ Assistance for all lows
- ☐ 3-4 glucose tablets (15 carbs)
- ☐ Retest in 15 minutes
- ☐ If < 70 repeat fast acting carb
- ☐ Retest in 15 mintes
- ☐ Notify Parent when:____________
- ☐ Notify Physician when:____________
- ☐ Glucagon injection for sever hypoglycemia
  Dose:________________
- ☐ Resume pump if blood sugar is > 70

For Hypoglycemia give 6-8 oz. of fruit juice, ½ candy bar, ½ carton of milk, PB crackers.

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 Provide:

1. The necessary supplies and equipment
2. Notify the school nurse if there is a change in my students health status of 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:____

Physician Authorization for Diabetes Management In School

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented. I understand that unlicensed designated school personnel under the training and supervision provided by the school nurse may perform specialized physical health care services. The 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.

Physicians Name__________________ Physician Signature ________________Date______

Phone______________ Fax______________ Address____________________

☐ Student has demonstrated proper use of medications to nurse

Reviewed by School Nurse (Signature) ________________________Date ____________

Maryville R-II School District
Diabetes Health History Form
For Management of Diabetes at School and School Sponsored Events

Student Name: ______________________________ Date: __________

Father/ Guardian ______________________ Phone ________________

Mother/ Guardian ______________________ Phone ________________

Physician ______________________ Phone ________________

Other Emergency Contact ______________________ Phone ________________

Date diagnosed with Diabetes ______________ Last Hospitalization __________

Has Glucagon ever been administered? ______________________________

Type of Insulin/ Oral Medication, Dose, and time given at Home:

1. ______________________________
2. ______________________________
3. ______________________________

Type of Insulin/ Oral Medication, Dose, and Time given at School:

1. ______________________________
2. ______________________________
3. ______________________________

Will the student require blood glucose checks at school?

Times:

____

____

____

Other health concerns: ______________________________

____

____

Is PE modification necessary? _____ Yes _____ No
Does student need snack prior to PE? _____ Yes _____ No
Will student self-administer medication at school? _____ Yes _____ No

______________________________ ______________

Parent/ Guardian Signature Date

MARYVILLE R-II SCHOOL DISTRICT
PARENTAL PERMISSION FOR
STUDENT MEDICATION ADMINISTRATION

The Maryville R-II School District's Medication Policy requires written parental/guardian consent prior to giving any prescription or over-the-counter medications at school. This form is to be completed for each medication given. **Medication is to be supplied in the original container with only a 30 day supply each time brought by a parent/guardian or other responsible adult. A new written medical provider order must be presented for any medication changes.**

If the medication is a prescription, ask your pharmacist to prepare two labeled containers, one to be kept at school and one for home. **THE VERY FIRST DOSE OF MEDICATION WILL NOT BE GIVEN AT SCHOOL.**

Student Name____Grade_____________

Name/Dosage of Medication____

Time to be Taken ____

Form of Medication/Treatment ____Tablet/Capsule ____Liquid ____Inhaler ____Other

Reason for Medication____

Physician's Name____

Medication to be Given From____________________TO_____________________________
(Start Date) (End Date)

When was First Dose of Medication Given? ____

List Student's allergies____

I request the above medication or treatment be administered to my child at school. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and for informing the school nurse immediately if any information provided on this form changes. I give permission for the school nurse to communicate with the above physician or medical provider regarding any questions or concerns about the above medication or treatment. I also agree to pick up any remaining medication within one day after the last day of school or the school will dispose of the medication.

____ ____________________
Parent/Guardian Signature Date

MARYVILLE R-II SCHOOL DISTRICT
AUTHORIZATION FOR SELF ADMINISTRATION OF MEDICATION AT SCHOOL OR AFTER-SCHOOL ACTIVITIES

In accordance with School Board policy JHCD, a student may carry and self-administer medication for the treatment of Asthma, Anaphylaxis, or Diabetes on district property, at district-sponsored activities, and in transit to and from school or activities in accordance with law. The district will not allow any student to self-administer medications unless:

1. The medication is prescribed by the student's physician and is in original container with directions for use.
2. The physician has provided a written treatment plan for the condition for which the medication is prescribed and certifies that the student is capable and responsible in use of the medication. The student must demonstrate to the physician or physician's designee the skill necessary to use the medication.
3. The student has demonstrated proper self-administration technique to school nurse.
4. The student's parent/guardian has signed a statement authorizing self-administration of the medication.

Name/Dose of Medication ____

Diagnosis for which medication is needed ___________________________________

I authorize the Maryville School District to allow my child to carry and self-administer medication for Asthma, Anaphylaxis, or Diabetes. I acknowledge that the district and its employees or agents will incur no liability as a result of any injury arising from the self-administration of such medication. The school nurse reserves the right to withdraw the privilege if the student shows signs of irresponsible behavior that could pose a safety or health risk.

Student's Name ____ Grade __________

Parent/Guardian Signature _____________________________________ Date ___________

The above student has been instructed in correct administration of above medication and has demonstrated correct technique. In my opinion, this student shows capability to carry and self-administer the above medication.

Physician Signature ____ Date ___________