Parent Consent and Health Care Provider Authorization for Insulin Dose During a Disaster

Pupil: _____ DOB: _____ Date: _____

Dose administered via ____prefilled syringe ____insulin pen ____syringe ____insulin pump

RECOMMENDATIONS
For students who do not carb count, if insulin is available but there is a limited food supply then consider decreasing the usual dose of NPH, Lente, Ultralente or Lantus by 25%. Regular or rapid-acting insulins may not be needed. Initial space below if in agreement:
____ If there is a limited food supply, decrease dose of long acting insulin by 25% and do not use short acting insulin.

Usual daily insulin regimen (decrease the following doses if limited food supply):
Insulin Brand Name and Type(s):_____

Breakfast

Lunch

Dinner

Bedtime

____ For students who are on pumps, carb count, and/or use multiple injections use the following calculations with (circle one) Regular Humalog Novolog

____ Insulin to carbohydrate ratio:
•_____#unit(s) insulin per _____gms Carbohydrate

____Correction calculation (complete only those that supply):
•Give _____unit(s) for every _____mg/dl above _____mg/dl
•Decrease correction by _____% unit(s) if PE or increased activity is anticipated after dose, or last dose was given less than 2 hours before
OR
____ 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

____Add carb calculation insulin dose and correction calculation for total insulin dose/bolus

AUTHORIZED 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 law governing school health services. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).
Authorized Health Care Provider Signature: _____Date: _____

Address: _____ City _____ Zip _____

Phone Number _____

PARENT OR GUARDIAN CONSENT
We(I), the undersigned, the parent(s)/guardian of the above named pupil, request that the above defined insulin doses be given during a disaster for our (my) child in accordance with State laws and regulations.

Parent/guardian Signature: _____ Date:_____

Reviewed by School Nurse (signature): _____ Date:_____

Reviewed by Principal (signature): _____Date:_____
Note: Completion of this form is for disaster purposes only. Failure to complete this form does not give reason for school exclusion.