

Belton ISD Health Services
Parental Authorization for Diabetic Care

School Year: _____ Campus: _____

Student Last Name	Student First Name	DOB	Grade/Homeroom	Transportation: <input type="checkbox"/> Rides bus # _____ <input type="checkbox"/> Car rider <input type="checkbox"/> Walker
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<input type="checkbox"/> No <input type="checkbox"/> Yes Student in Special Education Program?		<input type="checkbox"/> No <input type="checkbox"/> Yes Student in 504 Program? (School accommodations for those with chronic health conditions?)	
<input type="checkbox"/> Diabetes Type 1	Age diagnosed	In the past 3 months, has your child been treated for severe low or high blood sugar in the emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Diabetes Type 2			
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: <input type="checkbox"/> Yes* <input type="checkbox"/> No Continuous Glucose Meter: *All electronic equipment must be supplied by parent. No school I-pads or staff cell phones can be used.		Can student perform own blood sugar checks? <input type="checkbox"/> Yes <input type="checkbox"/> Yes, with assistance <input type="checkbox"/> No
Insulin administration: <input type="checkbox"/> pen <input type="checkbox"/> Syringe <input type="checkbox"/> Pump (type) _____ <input type="checkbox"/> None- <input type="checkbox"/> Takes oral medication _____ <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> Yes, with assistance <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes What blood sugar level is considered low for your child? _____ How often does your child typically experience low blood sugar? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> 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): <input type="checkbox"/> Yes <input type="checkbox"/> No
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes What blood sugar level is considered high for your child? _____ How often does your child typically experience high blood sugar? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> 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): <input type="checkbox"/> Yes <input type="checkbox"/> No
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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	

