HEALTH CARE PROVIDER ORDERS FOR STUDENTS WITH DIABETES IN WASHINGTON STATE SCHOOLS

STUDENT'S NAME ___________________________________________ Student's birthdate / / School ________ Grade ________

Emergency numbers for parents (phone) ____________ (Cell contact 2) ____________ (Cell) ____________

Doctor's phone number ________ Other contacts ________

HYPOGLYCEMIA (fill in individualized instructions on line or use those in parenthesis)

Unconscious (phone 911) (Other orders) __________________________

Blood sugar < 60 and symptomatic (juice, pop, candy) __________________________

Blood sugar < 100 and symptomatic (crackers/cheese) __________________________

Blood sugar < 80 and asymptomatic (feed partial meal) __________________________

Blood sugar > 100 and asymptomatic (feed partial meal) __________________________

Blood sugar at which parent should be notified—low high __________________________

BLOOD SUGAR AND INSULIN DOSAGE prior to lunch (R is regular and H is lis-pro,) ____________ any other insulin requested

Blood sugar < 100 ____________ units R - H - other (see hypoglycemia above)

Blood sugar 100-149 ____________ units R - H - other __________________________

Blood sugar 150-199 ____________ units R - H - other __________________________

Blood sugar 200-249 ____________ units R - H - other __________________________

Blood sugar 250-299 ____________ units R - H - other __________________________

Blood sugar 300-349 ____________ units R - H - other __________________________

Blood sugar 350-399 ____________ units R - H - other __________________________

Blood sugar > 400 ____________ units R - H - other __________________________

- Licensed medical personnel allowed to give ________ units (minimum) of insulin to ________ units (maximum) of R, H, other ________ insulin after consultation with the parent/guardian.

- Other insulin instructions (i.e., CHO counting) __________________________

- If urine ketones trace, small, moderate, large call parents (circle one or more)

DISASTER INSULIN DOSAGE in case of disaster how much insulin should be given? Recommend 80% of usual dose.

A.M. ____________ units R - H - other ________ units Lente NPH Ultra Lente Lantus other

Noon ____________ units R - H - other ________ units Lente NPH Ultra Lente Lantus other

P.M. ____________ units R - H - other ________ units Lente NPH Ultra Lente Lantus other

Bedtime ____________ units R - H - other ________ units Lente NPH Ultra Lente Lantus other

STUDENT’S SELF-CARE (ability level) Initials of: Parent HCP School Nurse

Totally independent management or __________________________

1. Student tests independently or student needs verification of number by staff or assist/testing to be done by school nurse (print/type) ____________ signature / / date

2. Student administers insulin independently or student self-injects with verification of number or student self-injects with nurse supervision or injection to be done by school nurse (print/type) ____________ signature / / date

3. Student self-treats mild hypoglycemia (print/type) ____________ signature / / date

4. Student monitors own snacks and meals (print/type) ____________ signature / / date

5. Student tests and interprets own urine ketones (print/type) ____________ signature / / date

6. Student tests and interprets own blood ketones (print/type) ____________ signature / / date

7. Student carries own supplies (print/type) ____________ signature / / date

HCP __________________________ signature / / date

Parent __________________________ signature / / date

School Nurse __________________________ signature / / date

Start date: ______ day ______ mo. ______ yr. Termination date: ______ day ______ mo. ______ yr. or End of school year: ______

Must be renewed at beginning of each school year.

Guidelines for Care of Students with Diabetes May 2005
Student Name: ______________________ Date of Birth: _______ Age: ___
Name of School: ___________________________ Grade: ______

Section A: To be completed by parent or guardian. Please check box(es) and sign below:

☐ I understand that if my child's medical or health needs change, it is my responsibility to notify my child's school nurse/health clerk and have a new Diet Prescription for Meals at School form completed.

☐ I give Nutrition Services permission to speak with the Physician or Authorized Medical Authority named below to discuss the dietary needs described below.

Parent/Guardian Signature ___________________________ Home Phone Number _______ Date Signed ________

Section B: To be completed by child's Physician / recognized Medical Authority (if describing a disability).

Does the child have a disability?  ☐ Yes ☐ No
If yes, describe the major life activity affected by the disability __________________________

Does the child have a non-disabling medical condition?  ☐ Yes ☐ No
If yes, describe the medical condition __________________________

Does the child have special nutritional or feeding needs?  ☐ Yes ☐ No
If yes, describe the specific need __________________________

If you answered YES to any of the questions above, complete Section C and return to the nurse/health clerk at the child's school.

Section C: PHYSICIAN REQUEST Diet Prescription:
(To be completed by the child's Physician or a recognized Medical Authority).

Note: For any food item to be omitted from diet, a substitute must be listed.

Foods to Omit:
________________________________________
________________________________________
________________________________________
________________________________________

Foods to Substitute:
________________________________________
________________________________________
________________________________________
________________________________________

Please attach additional instructions if necessary.

I certify that the student noted above needs special school meals prepared as described above because of the student's disability or chronic medical condition.

Health Care Provider Signature ___________________________ Date Signed ________
Name: ___________________________ Office Phone: __________________ Fax: __________________
Type or Print
## Authorization for Exchange of Medical Information

### SECTION I - INFORMATION REQUESTED FROM

<table>
<thead>
<tr>
<th>NAME/AGENCY</th>
<th>NAME OF PERSON DISCLOSING INFORMATION</th>
</tr>
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<tbody>
<tr>
<td>ADDRESS</td>
<td>TITLE</td>
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</tbody>
</table>

Name of Student | Birth Date | Date |

Specific nature of information to be disclosed:

### SECTION II - AUTHORIZATION

I hereby authorize the release of medical information as described in section I to the individuals who are affiliated with the school/agency indicated in section III.

This authorization expires 90 days after the date it is signed. This authorization expires on: 

<table>
<thead>
<tr>
<th>Parent Signature</th>
<th>Date</th>
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<tr>
<th>Student Signature</th>
<th>Date</th>
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*If the student is a minor but is authorized to consent to health care without parental consent under federal and state law only the student shall sign this authorization form.

**Student's Consent:**
- HIV/AIDS status, diagnosis, treatment - 14 years of age
- Family Planning/Abortion - no age limit
- Alcohol/Drug Treatment - 13 years of age
- Mental Health Services - 13 years of age

### SECTION III - AGENCY RECEIVING INFORMATION

<table>
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<th>NAME/AGENCY</th>
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ADDRESS

Name of School Psychologist

Name of School Nurse

Name of Other (indicate position title)

This information disclosed to you is protected by state and federal law. You are prohibited from releasing it to any agency or person not listed on this form without specific written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient. See chapter 70.02 RCW.

Envelope shall be marked "CONFIDENTIAL"
PHYSICIAN’S ORDERS FOR MEDICATION AT SCHOOL
Bethel School District

Patient: ____________________________ Date of Birth: ____________

Medication is ordered to be given to a student at school only when absolutely necessary. Whenever possible, the parent and physician are urged to design a schedule for giving medication outside of school hours. If this is not possible, it must be understood by the parent that the medication will be dispensed by the principal or his/her designee if the school nurse is not present. The principal will designate the person responsible to dispense medication on an individual basis. The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the physician’s directions.

Is it necessary to dispense this medication during school hours? ☐ Yes ☐ No

If yes, please give diagnosis or reason: ______________________________________

Drugs and dosage form: _____________________________________________________

Dose and method of administration: __________________________________________


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<thead>
<tr>
<th>Times Medication To Be Given</th>
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<tbody>
<tr>
<td>☐ Lunch</td>
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<td>☐ PRN - Specify length between doses:</td>
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<td>☐ Hour:</td>
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<tr>
<th>Duration Without Subsequent Order</th>
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<tbody>
<tr>
<td>☐ Weeks:</td>
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<td>☐ Months:</td>
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<td>☐ School Year:</td>
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<td>☐ Other:</td>
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Side effects of drug (if any) to be expected: ______________________________________

Inhaler to be carried by student: ☐ Yes ☐ No ☐ Not Applicable

Epinephrine auto injector to be carried by student: ☐ Yes ☐ No ☐ Not Applicable

_________________________ __________________________
Physician Signature Date

_________________________ __________________________
Physician’s Printed or Stamped Name Email Address

_________________________ __________________________
Telephone Number Fax Number

PARENTS MUST COMPLETE INFORMATION ON THE REVERSE SIDE OF THIS FORM.

(Rev 5/15/13)
PHYSICIAN'S ORDERS FOR MEDICATION AT SCHOOL
Bethel School District

PARENT PERMISSION

I request that the school nurse, principal or a staff member designated by him/her be permitted to dispense the following medication to my child:

<table>
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<tr>
<th>Name of Child:</th>
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<tbody>
<tr>
<td>Medication Prescribed:</td>
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<td>Name of Physician:</td>
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<td>Period of Time:</td>
<td>From: To:</td>
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The medication is to be furnished by me in the original container labeled by the pharmacy or physician with the name of the medicine, the amount to be taken, the time of day to be taken and the physician's name listed on the label.

I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with the physician’s directions. **This authorization is good for the current school year only.**

In case of necessity, the school district may discontinue administration of the medication with proper advance notice. **If notified by school personnel that medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed.** I am the parent or the legal guardian of the child named.

Inhaler to be carried by student: ☐ Yes ☐ No ☐ Not Applicable

Epinephrine auto injector to be carried by student: ☐ Yes ☐ No ☐ Not Applicable

_________________________  ______________________
Parent Signature          Date

_________________________  ______________________
Home Telephone            Cell Phone

_________________________  ______________________
Work Telephone            Email Address
INDIVIDUAL HEALTH/EMERGENCY CARE PLAN  
CONTACT INFORMATION

STUDENT NAME: ____________________________________________

Parent Email: ____________________________________________

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<tr>
<th>Name/Relationship</th>
<th>#1 Phone (type)</th>
<th>#2 Phone (type)</th>
<th>#3 Phone (type)</th>
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