Catholic Central High School, Troy, NY

Role of Parents/Guardians in Adjustment of Insulin Dose

Name:	DOB:	Gender: ☐ M ☐ F
Teacher/HR	Grade:	Date:

It is my professional judgment that _____, the parents/guardians of _____ have sufficient training and experience in adjusting insulin doses they administer to their child, and therefore should be consulted regarding the adjustment of insulin doses administered by a nurse during school time hours and at school-sponsored events, to the extent reasonably practical, understanding that the nurse retains his/her professional judgment regarding the adjustment dose he/she will administer. One or more of the following are a necessary part of diabetes care for their child in school. Please refer to separate diabetes medical orders for treatment specifics.

❑ Yes ❑ No	*Parents/guardians, as named above, should be contacted for consultation before administering a correction dose.
❑ Yes ❑ No	Parents/guardians, as named above, are authorized to propose an increase or decrease in the correction factor within the following range: *(select one)* +/- ___ units; OR +/- ___% of the prescribed dose according to written orders.
❑ Yes ❑ No	Parents/guardians, as named above, are authorized to propose an increase or decrease in the insulin-to-carbohydrate ratio within the following range: *(select one)* 1 units per prescribed +/- ___ grams of carbohydrate; OR +/- ___% of the prescribed dose according to written orders.
❑ Yes ❑ No	Parents/guardians, as named above, are authorized to propose an increase or decrease in the fixed insulin dose within the following range: *(select one)* +/- ___ units of insulin; OR +/- ___% of the prescribed dose according to written orders.
❑ Yes ❑ No	Parents/guardians, as named above, are authorized to propose an increase or decrease in the consumption of carbohydrates at any time within the following range: _____ grams of carbohydrates.
❑ Yes ❑ No	For children on insulin pumps: Parents/guardians, as named above, are authorized to propose a temporary basal rate increase or decrease by ____% for the duration of school time hours.

**If school personnel attempt to contact the parents/guardians, as named above, at the following telephone number provided by the parents/guardians ( ) ____-_____ on at least one occasion and the parents/guardians, as named above, are unable to be reached, and the school health professional determines using his/her professional judgment that treatment is necessary, the school health professional should follow the written orders provided by the health care provider, using his/her professional judgment.*

Health Care Provider:_____ _____
(please print name) (signature)

Phone:_____ Fax:_____ Date:_____