KENNEWICK SCHOOL DISTRICT

AUTHORIZATION FOR INSULIN PUMP USAGE AT SCHOOL

Student's Name: ____ Birthdate: _________________

School: ____ Grade: ___________________

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP)
(e.g., MD, DO, ARNP, DDS, etc.)

Type of Pump	Type of Insulin in Pump
Type of Infusion Set	
Carbohydrate to Insulin Ratio	
Blood Glucose Correction Factor	
Blood Sugar check with Insulin Bolus ☐ Before lunch ☐ Before snack ☐ Other: _________________________	

Student Pump Skills					
Skill	**Yes**	**No**	**Skill**	**Yes**	**No**
1. Independently counts carbs	☐	☐	7. Reconnects pump at infusion site	☐	☐
2. Gives correct bolus for carbs consumed	☐	☐	8. Gives injection with a syringe if necessary	☐	☐
3. Calculates and administers correction bolus	☐	☐	9. Fills reservoir or cartridge and primes tubing	☐	☐
4. Sets basal rate	☐	☐	10. Inserts infusion set	☐	☐
5. Sets temporary basal rate	☐	☐	11. Troubleshoots all alarms	☐	☐
6. Disconnects pump if necessary	☐	☐			

The above-named student is authorized to use an Insulin Pump and medication in accordance with the instructions indicated above from (date): ________________________ to (date): ________________________________

(not to exceed current school year).

LHP's Signature:____ Date: ____________________

LHP's Name:____(Please Print)

Phone Number: (_____) _____________ Fax Number: (_____) _____________

PARENT/GUARDIAN PERMISSION FOR INSULIN ADMINISTRATION AND INSULIN PUMP USAGE

The insulin pump and all supplies are to be furnished by me. I understand that my signature indicates my understanding that reasonable care will be exercised in supporting the usage of the pump at school. The school accepts no responsibility for adverse reactions when the pump is used in accordance with the licensed health professional's directions. I also understand the importance of being available for consultation and support with my student's insulin pump.

Parent Supplied Pump Supplies Required for School

1) Blood glucose meter with strips, lancet device with lancets
2) Extra pump supplies
3) Quick acting sugar, i.e. juice or glucose tabs
4) Carbohydrate/protein snack, i.e., peanut butter or cheese and crackers
5) Copy of basal rates and bolus dosing

Signature of Parent/Guardian: ______________________________________ Date: __________________

Home phone: __________________ Work phone: __________________ Cell phone: __________________

MEDICATION AT SCHOOL RULES

- Prescription medications must be in the original labeled container from the pharmacy.
- Over-the-counter medication must be in the original container.
- Any changes to this medication will require a new medication form completed by both parent and health care provider.
- Under normal circumstances prescribed **oral, nasal spray, topical, eye drop or ear drop** medication and over-the-counter **oral, nasal spray, topical, eye drop or ear drop** medication should be dispensed before and/or after school hours under supervision of the parent / guardian.
- Medications will only be dispensed at school when failure to receive the medication may result in the student being unable to attend school or to be well enough to participate in learning activities.
- If a student must receive prescribed or over-the-counter medication during school hours, the parent must submit a Medication at School form completed and signed by both the parent and a licensed heath care provider.
- Only the amount of medication needed during school hours for the course of the illness/condition is to be sent to school, not to exceed a one month's supply.
- Medications that must be given in half-pill doses must be cut by the pharmacy or the parent. The school will not cut pills.
- Parent or designated adult to bring medication to school (students should not transport medication to school).
- When the duration of a medication is complete or out of date, or at the end of the school year, the parent must pick up any unused portions of the medication. Unclaimed medications will be discarded.
- Bus drivers will not transport or administer medication.
- In case of necessity, the school district may discontinue administration of the medication with proper advance notice.

Note: This authorization is good for the current school year only

Authorization for Mutual Exchange of Confidential Information

Purpose: *As a parent, guardian or student, you have the right to give permission or not give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Family Education Right and Privacy Act. FERPA, (for example, transfer of records from one school district to another).*

Student Name: __________ Date: ________________ DOB: ____________________

I hereby authorize the release of records

From:		***To:***	
Agency/Person:		**Agency/Person:** ***KSD Nurse***	
Street Address:		**Street Address:**	
City, State, Zip:		**City, State, Zip:** ***Kennewick, WA,***	
Tel:	***Fax:***	***Tel: 509-222-***	***Fax: 509-222-***

Describe records to be disclosed: ***Diagnoses, medication, medical recommendations applicable for student at school.***

The reason for disclosing the record(s) is: ***To provide safe care of the student in the educational setting***

This authorization is valid from: _____/_____/_______ to: _____/_____/_______.

I understand that this information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).

I understand my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

Parent/guardian/student signature:	Date: