DIOCESE OF FORT WORTH

# Parental Authorization for Diabetes Action Plan 2025-2026

**Name:_____DOB_____Grade/Teacher: _____**

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Before/After school activities: ☐ Athletics ☐ Band ☐ Club ☐ Tutoring ☐ Other: _____

Physician: _____

Physician Phone number: _____

Date or age of diabetes diagnosis: _____ ☐ Type 1 ☐ Type 2

In the last year has student been treated in the emergency room for high or low blood sugar? ☐ No ☐ Yes

Lunch will primarily be: ☐ Brought from home ☐ Purchased from cafeteria

## Checking Blood Glucose

Brand/model of blood glucose meter: _____

Target range of blood glucose before meals: ☐ 90-130mg/dl ☐ Other:_____

Blood glucose level is checked (*select all that apply*):

- ☐ Before breakfast
- ☐ After breakfast
- ☐ ____ hours after breakfast
- ☐ 2 hours after a correction dose
- ☐ Before Lunch
- ☐ After Lunch
- ☐ ____ Hours after lunch
- ☐ Before dismissal
- ☐ Mid-Morning
- ☐ Before PE
- ☐ After PE
- ☐ As needed for signs of illness
- ☐ As needed for signs/symptoms of low or high blood glucose

## Student's Self-care blood glucose checking skills:

*Please indicate whether student can perform the following skills independently*

| | | |
|---|---|---|
| ☐ No | ☐ Yes | Independently checks own blood glucose. |
| ☐ No | ☐ Yes | May check blood glucose with supervision |
| ☐ No | ☐ Yes | Requires school nurse or trained diabetes personnel (UDCA) to check blood glucose |
| ☐ No | ☐ Yes | Uses a smartphone or other monitoring technology to track blood glucose values |

Does student have a continuous glucose monitor (CGM)? ☐ No ☐ Yes, Brand/model:_____

## Student's self-care CGM skills:

*Please indicate whether student can perform the following skills independently*.

| | | |
|---|---|---|
| ☐ No | ☐ Yes | My student can troubleshoot alarms and malfunctions independently |
| ☐ No | ☐ Yes | My student knows what to do and disable to deal with a HIGH alarm |
| ☐ No | ☐ Yes | My student knows what to do and I able to deal with a LOW alarm |
| ☐ No | ☐ Yes | My student can calibrate the CGM |
| ☐ No | ☐ Yes | My student knows what to do when CGM indicates a rapid trending rise or fall in the blood glucose level. |

## Insulin Therapy

Insulin delivery device: ☐ Syringe ☐ Insulin Pen ☐ Insulin pump ☐ None, takes oral medication_____

Insulin therapy at school: ☐ Adjustable (basal-bolus) Insulin ☐ Fixed insulin therapy ☐ No insulin

Name/brand of insulin: _____

Student's self-care insulin administration skills:

*Please check all that apply*

- ☐ Independently calculates and gives own injections.
- ☐ May calculate/give own injections with supervision.
- ☐ Requires school nurse or trained diabetes personnel to calculate dose & student can give own injection with supervision.

☐ Requires a school nurse or trained personnel to calculate dose and give the injection.

## Hypoglycemia

Common signs of hypoglycemia (low blood sugar) are hunger, irritability, lethargy, sleepiness, light-headedness, headache, shakiness, pale skin, profuse sweating, cold and/or clammy skin, disorientation, inability to follow directions, rapid breathing, faintness, rapid heartbeat, unconsciousness, and convulsions.

Please describe your student's usual behavior/symptoms of hypoglycemia:_____

_____

What blood sugar level is typically considered low for your student?_____

Does your student recognize his/her low blood sugar symptoms? ☐ No ☐ Yes ☐ Sometimes

Can your student independently treat his/her low blood sugar? ☐ No ☐ Yes

Is there a typical time of day your student experiences low blood sugar? ☐ No ☐ Yes, specify_____

**Emergency Treatment:**

*If your student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions, the school nurse or Unlicensed Diabetic Care assistant will follow the Diabetes Management Plan provided by the doctor and do the following:*

- Position student on his/her side to prevent choking
- Administer glucagon (must be provided by parent and medication orders received from physician)
- Call 911 to initiate Emergency Medical Services
- Call Student's parents

## Hyperglycemia

Common signs of hyperglycemia (high blood sugar) are thirst, changes in behavior, frequent urination, headache, warm dry skin, blurred vision, rapid heartbeat, rapid breathing, nausea and/or vomiting.

Please describe your student's usual behavior/symptoms of hyperglycemia:_____

_____

What blood sugar level is typically considered high for your student? _____

Does your student recognize his/her high blood sugar symptoms? ☐ No ☐ Yes ☐ Sometimes

Can your student independently treat his/her high blood sugar? ☐ No ☐ Yes

Is there a typical time of day your student experiences high blood sugar? ☐ No ☐ Yes, specify:_____

**Emergency Treatment:**

*If your student shows signs of a hyperglycemic emergency (dry mouth, extreme thirst, vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increased sleepiness or lethargy, or a depressed level of consciousness) the school nurse or Unlicensed Diabetic Care Assistant (UCDA) will follow the Diabetes Management Plan provided by the doctor, notify the parents, and call 911 to initiate Emergency Medical Services.*

**Parental Authorization**

I hereby grant permission for _____ ("School") to follow the above Action Plan for my child and to take whatever measure in their judgment may be necessary to provide emergency medical services consistent with this Action Plan, including the administration of medication to my child. I give permission to School to contact my physician for additional information as necessary. I grant the school permission to share this Action Plan with my student's teacher(s). I also authorize School staff members to share the contents of my child's Action Plan with other School employees, volunteers, or chaperones at school events or field trips as necessary to ensure the safety and well-being of my child. I agree to defend, indemnify, and hold harmless the Diocese of Fort Worth, its parishes and Catholic schools, its bishop and successor bishops, and all their priests, employees, servants, volunteers, and agents (collectively, the "Releasees"), from and against any and all claims, demands, causes of action, judgments, damages, liabilities, or losses of any character, arising out of or in any way connected with the provision of medical services, the enacting of the Action Plan, or the failure to provide any medical services or medication. Further, on behalf of myself and the other parent/guardian of the student, I hereby release and waive all claims, demands, or causes of action against the Releasees.

_____

**Parent/Guardian Signature Date**