

Ogden Community Schools
Independent Diabetes Medical Management Plan

Permission to Self-Carry and Self Administer Diabetes Care

To be completed by physician/diabetes educator, parent/guardian and student. This Form serves to inform everyone of expectations and responsibilities.

Student Name: _____ **Birthdate:** _____

Student's physician or licensed nurse practitioner or diabetes educator confirms that the student has a diagnosis of diabetes, is independent and can perform diabetes care, and has approval to self-administer his/her diabetes care including:

___ Glucose monitoring

___ Insulin calculation and administration (including pump operation & pump equipment)

The student understands that he/she is to promptly report to the school nurse or adult as soon as symptoms of high or low blood glucose appear or when not feeling well.

I agree to prepare a written Diabetes Medical Management Plan in consultation with the student's parents and appropriate school personnel.

Specific Duration of Order: _____

Physician/Provider Signature: _____ **Provider Printed Name:** _____

Office Phone: _____ **Office Fax:** _____

Date: _____

My child has been instructed in and understands his/her diabetic self-management. My child understands that he/she is responsible and accountable for carrying and using his/her medication and equipment.

I will provide the school nurse/school administrator with a copy of my child's Diabetes Medical Management Plan signed by his/her physician.

I hereby give my permission for the school to contact the above physician/nurse practitioner/diabetes educator regarding my child's diabetes care (authorization required if contact is other than the school nurse).

I will not hold the school board or any of its employees liable for any negative outcomes resulting from self-administration of diabetes medication by my child.

I understand that the school nurse, after consultation with the parent/guardian and school administrator, may impose reasonable limitations or restrictions upon my child's possession and self-administration of diabetes medications relative to his/her age and maturity or other relevant considerations.

I understand that the school administration may revoke permission to possess and self-administer said diabetes medication at any point during the school year if it is determined that my child has abused the privilege of possession and self-administration or he/she is not safely and effectively self-administering the medication. In addition, my child could be subject to further disciplinary action.

Parent/Guardian Signature

Date

Student Signature

Date