

**INSTITUTION NAME**

Institution Address

**DEPARTMENT**

**DIABETES MEDICAL MANAGEMENT PLAN**

Patient Label or MRN, Acct#, Patient name, DOB, Date of Service

**Part 4: Permission to Self-Carry and Self Administer Diabetes Care**

To be completed by physician/provider, parent/guardian and student. This form is not required by law, but serves to inform everyone of expectations and responsibilities.

**Student Name:** \_\_\_\_\_

**Birthdate:** \_\_\_\_\_

Student's physician or licensed nurse practitioner 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 student's parents and appropriate school personnel.

|   |                                     |                              |   |
|---|-------------------------------------|------------------------------|---|
| Specific duration of order:<br><b>2011-2012</b><br><b>SCHOOL YEAR</b> | Physician/Provider Signature: _____ | Provider Printed Name: _____ | Office Phone: xxx-xxx-xxxx<br>Office Fax: xxx-xxx-xxxx<br>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 permission for the school to administer the medications as prescribed in the care plan, if indicated (ie. Student requests assistance or becomes unable to perform self-care).

I also give permission for the school to contact the above physician/nurse practitioner 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 the 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*