**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: **SCHOOL YEAR** | 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 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 posses 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*