AUTHORIZATION FOR INDEPENDENT DIABETES CONSENT AND REQUEST

Date: _____

STUDENT NAME:_____ DOB _____ SCHOOL _____

Diabetes Mellitus __Type 1 __Type 2

- This student is independent in self-managing all aspects of his/her diabetes care, including self-administration of medication, and does not need supervision or assistance from school personnel

LICENSED HEALTH CARE PROVIDER PLAN OF CARE FOR STUDENT TO FOLLOW FOR SELF MANAGEMENT OF DIABETES WHILE AT SCHOOL:

- Check blood glucose
- If blood glucose below _____, consume 15-30 grams fast acting carbohydrate
- If blood glucose remains below _____ after 10-15 minutes, request adult escort to the school health office

Other:_____

- If blood glucose above _____, check ketones and drink 12 to 24 oz water
- If moderate ketones present and blood glucose above 300, request adult escort to health office
- If symptoms persist or become worse, request adult escort to school health office
- Administer _____(medication) via __ pump __ insulin pen
  __ syringe as directed by your licensed health care provider

If pump, type of pump _____ Other diabetes medications prescribed _____

Other orders/Directives _____

Licensed Health Care Provider Signature _____ Date _____

THE FOLLOWING EMERGENCY INTERVENTIONS AND 911 WILL BE IMPLEMENTED BY SCHOOL PERSONNEL AS FOLLOWS:

If student is semi-conscious, unconscious or unable to swallow, school personnel begin standard emergency procedures and activate the school's lock down/shelter in place plan while emergency crews are en route.

If student reports moderate to severe diabetes symptoms, have them check blood glucose; if blood glucose below 75 and able to swallow, he/she will be encouraged to consume fast acting carbohydrates while the school's shelter in place plan is activated and 911 is enroute.

THIS ORDER AND REQUEST EXPIRES AT THE END OF THE SCHOOL YEAR

Student Name _____ DOB _____

Consent and Request for Student to Self-Manage Diabetes Care, Including Administration of Medication

- I agree that my child can self-manage his/her diabetes and can recognize when he/she needs to seek help from a staff member.
- I authorize my child to carry and self-administer diabetes medication and management supplies and I agree to release Bondurant-Farrar Community School District and school personnel from all claims of liability if my child suffers any adverse reactions from self-management or storage of diabetes medication and blood glucose management products.
- I will provide backup supplies to the health office for emergencies. I will provide…..
    - _____
    - _____
    - _____
- I understand that this contract is in effect for the current school year unless revoked by my son/daughter's physician or my son/daughter fails to meet the safety guidelines contract below.

Parent/Guardian Name (please print) _____ Phone_____

Parent/Guardian signature _____ Date _____

Health Care Provider Name (please print) _____

PHONE _____ FAX _____

Student contract

- I agree to dispose of any sharps either by keeping them in my kit and taking them home, or placing them in the sharps container provided at school.
- If so indicated in my Individual Healthcare Plan, I will notify the health office if my blood sugar is below _____mg/dl or above _____mg/dl
- I will not allow any other person to use my diabetes supplies
- I plan to keep my diabetes supplies: __ with me __ in the school health office
    - in an accessible and secure location (_____)
- I plan to keep my emergency glucagon __ with me __ in the school health office
    - in an accessible and secure location (_____)
- I will seek help in managing my diabetes from _____ if I need it
- I understand that the freedom to manage my diabetes independently is a privilege and I agree to abide by this contract

Student's signature _____ Date_____

THIS ORDER AND REQUEST EXPIRES AT THE END OF THE SCHOOL YEAR