The Center ISD policy allows a responsible, trained student to carry and/or self-administer medication for diabetes on his/her person for immediate use in an emergent situation on school property or after-school activity. **This requires written order of physician, parent request, and school nurse/administrator approval.**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_Grade/Teacher\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESCRIBING HEALTHCARE PROVIDER RECOMMENDATION: (please check one)**

* I have instructed the student above in the proper procedure for diabetes care and how to use his/her medications. It is my professional opinion that he/she **SHOULD** be allowed to carry and self-administer his/her diabetes medications as well as independently perform the tasks necessary for diabetes management while on school property or at school-related events.
* The student above, in my professional opinion, **SHOULD** **NOT** be allowed to carry and self-administer any of his/her diabetes medications) while on school property or at school-related events.

Physician signature\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(\*If physician has consented to this within the DMTP, this form does not have to be signed by the physician)

**PARENT/GUARDIAN RECOMMENDATION:(Please check one:)**

* I **DO** consent for my child to self-manage his/her diabetes by self -carrying his/her supplies and self-administering his/her insulin without the assistance of a nurse or trained personnel. I have read the CISD Medication Policy and agree to abide by it. My child has been instructed in the proper way to use his/her medication as well as perform the tasks necessary for diabetes management. He/she can also recognize when he/she needs to seek help from a staff member. I understand that the school nurse will also assess my child’s knowledge and ability to identify symptoms and self administer his/her diabetes medications and perform tasks necessary for diabetes management, and may supervise this responsibility temporarily. I also understand that the school nurse and/or the principal reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or if there is a safety risk. I permit the school nurse, a specially trained person, or EMS to provide emergency care as needed. I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-management of diabetes and self administration of his/her insulin.
* I **DO NOT** consent for my child to carry or use his/her own medication or perform any of the tasks necessary for management of diabetes without supervision and/or assistance from the nurse or trained personnel. I give permission for a district trained health professional to manage my child’s diabetes according to prescribed orders from his/her health care provider.

Parent signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STUDENT CONTRACT**

*By initialing each statement and signing below, I indicate my understanding and agreement with the following statements:*

\_\_\_\_\_\_\_ I know how and when to use my check my blood sugar and have discussed this with my doctor

\_\_\_\_\_\_\_ I know it is my responsibility to keep my medications and supplies with me where it is easily accessible in case I need it during school hours, extracurricular activities, and field trips. Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ I will use universal precautions and dispose of my sharps properly by either keeping them in my kit and taking them home, or placing them in the sharps container in the nurse’s office

\_\_\_\_\_\_\_ I will notify the nurse or a responsible school adult if I am experiencing signs and symptoms of high or low blood sugar that does not resolve after initial treatment.

\_\_\_\_\_\_\_ I will notify the nurse or a responsible school adult if my blood sugar is below \_\_\_\_\_\_\_\_\_\_\_\_ or above \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ I will notify the school nurse and my parents if my medication or supplies are lost, stolen, or expired

\_\_\_\_\_\_\_ I will not share my medications or supplies with anyone else

\_\_\_\_\_\_\_ I understand that it is advised that I bring “back-up” supplies and medications to be stored in the nurse’s office

Student Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_