SELF-MANAGEMENT OF DIABETES AT SCHOOL
Health Services Department

Tri County Schools

PARENT/GUARDIAN: By signing below, you are acknowledging the following:

1. You are requesting that your child be allowed to self-manage his or her diabetes at school.
2. You are affirming your confidence that your child has the knowledge and skills needed to self-manage his or her diabetes safely at school.
3. You will provide an annual, written diabetes care plan, accompanied by medical orders for necessary medications and treatments to the school. We request you use the Diabetes Action Plan, or provide complete and equivalent information.
4. You are aware that you are not required to make the request for your child to self-manage his or her condition. Your child may continue to utilize the health office for diabetic cares, and may request assistance at any time during the school day from qualified school health personnel in the school health office.
5. If your student injures school personnel or another student as the result of misuse of necessary diabetic medical supplies, you shall be responsible for any and all costs associated with such injury.
6. The school and its employees and agents are not liable for any injury or death arising from a student's self-management of his or her diabetic condition.
7. You will indemnify and hold harmless the school and its employees and agents against any claim arising from a student's self-management of his or her diabetes.
8. These are in effect until rescinded by any party.

_____ _____

Parent/Guardian Printed Name *Student Name (printed)*

_____ _____

Parent/Guardian Signature *Date*

STUDENT: By signing below, you agree that you understand:

1. You must not share, or allow any one to handle, your medications or supplies.
2. If you need your medications, and do not receive relief when you use them, you will notify a teacher that you need assistance and/ or make your way to the health office.

_____ _____

Student Signature *Date*

_____

Student Printed Name

I_____ , authorize_____

Printed MD Name

to self manage his/her diabetes at school.

_____ _____

MD Signature *Date*