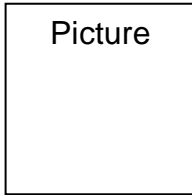


Student Name: _____ DOB _____
 Parent/Guardian _____ Phone _____
 Emergency Contact _____ Phone _____
 Treating Physician _____ Phone _____



LOCATION OF DIABETIC SNACKS: _____

SNACK TIMES DURING SCHOOL DAY: Mid Morning Mid Afternoon Other _____

SPECIAL EVENT/PARTY FOODS: Parent/Guardian Discretion Student Discretion Other _____

LOCATION OF GLUCOSE METER: _____

IS GLUCAGON ORDERED? YES NO LOCATION OF GLUCAGON: _____

OTHER DIABETES MEDICATION(s) AT SCHOOL or TAKEN AT HOME

Name: _____ Dose: _____ Route: _____ Time(s) _____

Name: _____ Dose: _____ Route: _____ Time(s) _____

During an overnight field trip, 'at home' medication: requires a trained staff member to administer medication

is authorized to carry and self administer medication

DIABETES MANAGEMENT: HEALTHCARE PROVIDER must provide a signed diabetes management plan from your facility. It must specify the following: Blood Glucose Monitoring, Insulin type and route of administration, Approved treatment of hypo and hyperglycemia, Approved Sports plan (if applicable), Parental Authorization to adjust Insulin dose and a Disaster Plan.

INSULIN THERAPY

Insulin delivery device: syringe insulin pen insulin pump

Student's self-care carbohydrate counting and insulin administration skills:	Student's self-care carbohydrate counting and insulin pump skills:
Carbohydrate Calculation <input type="checkbox"/> Student <input type="checkbox"/> Student requires assistance	Carbohydrate Calculation <input type="checkbox"/> Student <input type="checkbox"/> Student requires assistance
Calculate Insulin Dosage <input type="checkbox"/> Student <input type="checkbox"/> Student requires assistance	Calculate Insulin Dosage <input type="checkbox"/> Student <input type="checkbox"/> Student requires assistance
Insulin Administration <input type="checkbox"/> Student <input type="checkbox"/> Student requires assistance	Insulin Administration <input type="checkbox"/> Student <input type="checkbox"/> Student requires assistance
	Alarms or Malfunctions <input type="checkbox"/> Student <input type="checkbox"/> Contact Parent/Guardian

Blood Glucose/Sugar Monitoring During School Hours: Classroom Health Unit Other _____

Student checks blood sugar level independently and must keep testing supplies with them at all times.

Student checks blood sugar level independently in the health unit Student checks blood sugar level with assistance/supervision



If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions

Administer: Glucagon as prescribed: _____

Call 911 (Emergency Medical Services) & Contact the student's parents/guardian.

Being the parent/guardian of the above named student, I give consent for the information on this form—and the diabetes management plan-- to be shared with school personnel having direct contact with my child for the current school year. I understand that a trained staff member may administer prescribed medication and/or assist my child to comply with his/her physician's prescribed medications or treatments if needed. If my child's physician gives authorization for my child to carry and self-administer his/her medication, I consent and understand that medication independently self administered is not monitored by school staff. I agree to provide the necessary prescribed medication or treatment supplies and agree to notify the school nurse immediately of any changes.

The school nurse shall contact the student's Parent/Guardian to discuss any concerns regarding the student's care which might require medical follow-up and/or shall contact the health care provider to obtain current information verbally when necessary to manage the student's condition at school. I understand that the Montgomery County Board of Education Medication Policy and Procedures (09.2241) are readily available for me to read. I hereby agree to release and hold Montgomery County Schools free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment described by me or prescribed by my child's physician. I have read and understand this consent. I sign it voluntarily and with full knowledge of its significance.

X _____
 Parent/Guardian Signature

 Date Signed