Forest Lake Area Schools
Health Services - Nursing

Self-Management of Diabetes Agreement

School Year: ________________

This form is optional and is for students in 7th-12th grade **ONLY**. In order for the student to self-manage their diabetes and administer their diabetic medications at school, we **MUST** have all of the following updated every new school year:

- This form is to be completed by the student's endocrinologist/physician, parent/legal guardian, student, and Licensed School Nurse (LSN). All must agree and sign off on the below plan
- Authorization for Administration of Medication at School Form
- Self Carry/Self Administer Medication Authorization Form
- A physician's diabetic care plan/orders (in case of an emergency)

**Please note: If the student is prescribed glucagon, we ask that it be kept in the health office for availability during an emergency.

To be completed by the prescribing Endocrinologist/Health care provider

I believe that______________________________ is capable of independent blood glucose monitoring and self-administering the following medication:

Medication	Dose	Route	Frequency

Comments: ____

______________________________ ______________________________
Health Care Provider Signature **Health Care Provider Printed Name**

______________________________ ______________ ______________
Clinic Phone Date

To be completed by the Parent/Legal Guardian

- ☐ I hereby give my permission for my child to be independent in their blood glucose monitoring and self-administration of the above medications, as prescribed by my child's prescribing health care provider, while at school.
- ☐ I authorize reciprocal release of information related to my child's health/medications between the school nurse and the above prescribing health care provider.
- ☐ I have directed my student on the proper dosage and frequency per doctor's order.
- ☐ I understand that all forms listed above **MUST** be provided to the school's health office in order for my student to self-manage their diabetes and administer their diabetic medications.
- ☐ I understand that the school will **NOT** provide a diabetic trained staff member to accompany my student on any field trips.

______________________________ ______________________________ ______________
Parent/Legal Guardian Signature Printed Name Date

______________________________ ______________________________
Daytime Phone Number Back-up Phone Number

Student Agreement:
I, _____________________________agree to the responsibilities of carrying medication and managing my own diabetes.

SKILL	STUDENT INITIALS	NURSE INITIALS	COMMENTS
Medication will be properly labeled for the student by pharmacist (prescription) or parent (OTC).			
Student demonstrates correct use/administration of medication			
Student can recognize correct dosage			
Student recognizes proper and prescribed timing for medication			
Student agrees to not share the medication with others			
Student will keep the medication in an agreed upon location ● Location: ___________________			
Student will keep a second labeled container in the health office (optional)			
Student will notify the Health Services Office under the following circumstances: ● Symptoms continue or get worse after taking my medication ● Suspect that I am experiencing side effects from the medication ● Other________________________			
Student will follow the health care provider's orders			
Student agrees to keep supplies on hand to treat low blood sugar and to manage the diabetes if pump malfunctions (okay to keep in health office if agreed by all)			
Student agrees to check in with the nurse on a ______ basis. (Note day and time)			
I will call my health care provider if I am having blood sugars that are consistently out of my goal range			

Permission for self-administration of medication may be suspended if the student is unable to maintain the procedural safeguards established in the above agreement. If there is disagreement related to this procedure, the case may be referred to the Building Principal and District Nurse.

☐ The student has demonstrated the specified responsibilities and may self-carry/administer the indicated medications.

______________________	______________________	______________
(Student Signature)	**(RN/LSN Signature)**	**(Date)**

NOTE: If the school nurse does not concur with the health care provider's instructions after assessing the competencies of the student, the school nurse will contact the health care provider and parent/legal guardian to agree upon a plan. Permission for the self-administration of medication may be suspended if the student is unable to maintain the procedural safeguards established in the above agreement.