Darlington County School District
Diabetes Self-Management Plan

School Year: _____

Student Name: Grade:	School:
Parent/Guardian Name:	Home Phone:
Address:	Work/Cell Phone:
Healthcare Provider:	Phone: Fax:

Student Agreement:

I agree to:

- ☐ Follow the orders that are prescribed by my healthcare provider.
- ☐ Check blood glucose and administer insulin accordingly.
- ☐ Use correct blood glucose monitoring and insulin administration techniques; dispose of all sharps in the sharps container in the office area or in personal supply container.
- ☐ Notify the nurse or office if my blood glucose is below _____ mg/dl or above _____ mg/dl.
- ☐ Not allow any other person to use my diabetes supplies.
- ☐ Maintain my supplies at school with extra emergency supplies kept in the nurse's office.
- ☐ At all times have with me fast acting glucose supplies (juice box, tablets) and snacks to treat low blood glucose levels.
- ☐ Manage all aspects of my diabetes care in cooperation and communication with my parents as ordered by my healthcare provider on the Diabetes Medical Management Plan.

_____ _____

Student Signature Date

Parent/Guardian Agreement:

I agree that:

- ☐ I will keep supplies in stock for my student for effective diabetes management.
- ☐ I will allow reciprocal release of information related to my child's health/medications between the school nurse and the prescribing healthcare provider.
- ☐ My child will manage all aspects of their diabetes care in cooperation and communication with myself/parents as ordered by their healthcare provider on the Diabetes Medical Management Plan and agrees to seek help from school personnel as needed.
- ☐ School personnel will not be responsible to provide my child with daily reminders of the need to adhere to this self-management plan.
- ☐ Unless otherwise noted, this contract will remain in effect for the school year unless revoked by the healthcare provider or myself or if the student fails to meet the above safety contingencies.

_____ _____

Parent/Guardian Signature Date

School Nurse Agreement:

- ☐ School staff that have the need to know about the student's condition and the need to carry their diabetes supplies have been notified.
- ☐ This student has demonstrated knowledge related to his/her diabetes medication and self-care skills.

_____ _____

School Nurse Signature Date