PAPILLION LA VISTA COMMUNITY SCHOOLS

Medical Self Management Plan Authorization

Student Name:_____ **Date of Birth:** ____/____/____
month day year

School:_____ **Grade:**_____

Medical Provider Authorization and Approval

❑ I have reviewed and approve the attached Action Plan. The student has the ability to safely and responsibly self-manage his/her condition in accordance with this Action Plan.

Medical Provider Name (please print) | Phone

Medical Provider Signature | Date

Parent/Guardian Approval and Liability Waiver for Self-Management

The parent/guardian of the student hereby accepts and agrees to the attached Action Plan. The parent/guardian understands and agrees that if the student injures school personnel or another student as a result of the misuse of necessary medical supplies, the parent/guardian of the student shall be responsible for any legal liability and all costs associated with such injury. The parent/guardians acknowledges that (a) the school and its employees/agents are NOT liable for any injury or death rising from the student's self-management of the health condition and the parent/guardian releases same from any such claims, and (b) the parent/guardian shall and does hereby agree to indemnify and hold harmless the school and its employees/agents against any claim arising from the student's self-management of this health condition. This release, indemnification and hold harmless agreement shall take effect immediately and shall stay in effect for as long as the student is provided permission to self-manage his/her condition.

Parent/Guardian Signature | Date

Student Agreement for Self-Management

I will use the prescription medication only as prescribed and as permitted by the attached Action Plan. I will NOT share it with others. I have been instructed how to self-administer this medication and understand the side effects of improper use and will promptly report self-administration and will follow the Guidelines. I agree to abide by the Action Plan in regard to using any testing equipment/materials needed to manage my medical condition. I understand that if I do not abide by these terms, I may be disciplined and that this Action Plan will be re-evaluated by school personnel.

Student Signature | Date

School Nurse Approval for Self-Management

❑ I have reviewed and approve the attached Action Plan. The student has the ability to safely and responsibly self-manage his/her condition in accordance with this Action Plan.

School Nurse Signature | Date

Revised: 02/2016