Worthington Schools
DIABETES CARE AT SCHOOL

**** This form must be completed and signed by a Physician and Parent/Guardian for each school year.**

Student's Name: ___________________________**Grade/Teacher:** ____________________**School Year:** ___________

☐ I understand that my child may be eligible for a 504 Plan and I will contact the school principal if interested.

Physician's Section

Physician's Name/Title: ____ **Phone:** _________________________

This is to certify that the above student is under my care for treatment of Diabetes and has been prescribed an insulin pump, insulin pen or draw up syringe to provide his/her insulin.

Please check ONE of the following with regard to the student's Diabetes care at school:

☐ This student is fully instructed and capable of independently calculating carbohydrates, calculating corrections based on the blood sugar, determining insulin boluses and self-administering insulin via insulin pump; insulin pen or draw up vial/syringe

☐ This student is unable to administer his/her own insulin at this time and will need school staff to administer insulin, based on physicians orders, via:

- ☐ draw up insulin syringe from vial
- ☐ insulin dial up pen
- ☐ insulin pump

☐ This student will require supervision or assistance with the following skills:

- ☐ blood sugar checks
- ☐ carbohydrate calculations
- ☐ calculating insulin bolus
- ☐ interventions for high or low blood sugar
- ☐ corrections
- ☐ administration of insulin

➡ **Physician Signature:** _________________________________**Phone:**____________________**Date:**_____________

Parent/Guardian's Section

Request for Administration of Glucagon Injection by School Personnel

I hereby request and give my permission for school district personnel to administer the prescribed Glucagon to my child in accordance with the specific written instructions of the medical provider. I hereby release the Worthington City School District, its Board of Education, its officials and employees including the school nurse and the nurse's designee from any and all liability for damages or injury directly or indirectly resulting from the performance or failure of performance of the assistance requested. I am responsible for the delivery of the Glucagon to the school clinic and will notify the school immediately if we change our medical provider or the need for Glucagon is terminated.

I understand this medication can only be administered to my child by a school nurse or myself until volunteer staff in my child's school have completed the required District training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff is authorized to perform this task and 911 will be called whenever Glucagon is given. I agree to provide a separate Glucagon to school staff supervising my child's extracurricular activities.

➡ **Parent/Guardian Signature:** ________________________________**Phone:**_____________**Date:**_________

☐ **Please check here to acknowledge that Parents/Guardians are responsible for providing ALL diabetes supplies needed at school including juice & snacks.**