



# Cape Henlopen School District

## Parental Request/Permission for Management of Diabetics

If it is necessary for your child to receive medication/treatments during the school day, please do the following:

- Send the medication to school with a responsible individual if you are unable to take it to school.
- Send the medication in the original container. If a prescription, the container must be properly labeled with correct name, time, dose, date, and prescribing licensed healthcare provider.
- Count the tablets (unless the number of tablets is the exact number on the label) or approximate the amount of liquid in the bottle.
- Pick up the medication/supplies from the school at the end of the school year.

**Date:** \_\_\_\_\_ **Student Name:** \_\_\_\_\_

**Reason for Medication:** \_\_\_\_\_

**Allergies to any Medications:** \_\_\_\_\_ **Provider:** \_\_\_\_\_

**Comments/Health Conditions:** \_\_\_\_\_

**Diabetic Medications/Supplies:** \_\_\_\_\_

**Insulin (via insulin pump, insulin pen, or syringe):** \_\_\_\_\_

**Glucagon/Baqsimi:** \_\_\_\_\_

**Ketone Checks (Indicated blood or urine):** \_\_\_\_\_

**Finger Sticks (check one):**  YES  NO

**Continuous Glucose Monitoring:**  YES  NO

**DMMP Received:**  YES  NO

**I give permission for this medication to be sent on Field Trips during the current school year and for a trained staff member to assist with administration:**  Yes  No (Check One)

I am aware that the school nurse may need to contact the prescribing healthcare provider or pharmacist relative to the medication/treatment and that he/she is required to use nursing judgement regarding all medication administration. I give my permission for medication administration by the school nurse.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Nurse Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_