

Self Management of Asthma, Anaphylaxis, and Diabetes

Student Name: _____ DOB: _____ Medical Condition: _____

Healthcare Provider Consent for Student Self Management of Care

I have reviewed and approved the provided health plan and included any recommended modifications. This consent is for a maximum of one year. If changes in procedure are indicated, I will provide written orders accordingly. I have instructed this student in the proper use of his/her medications and supplies.

- ☐ Student should be allowed to carry and administer medication independently and should report event to the nurse any time after self administering
- ☐ Inhaler
 - ☐ Epi-Pen
 - ☐ Diabetic Supplies

Healthcare Provider Signature

Date

- ☐ **See EAP for Provider Signature**

Self Management of Asthma, Anaphylaxis, and Diabetes

Student Name: _____ DOB: _____ Medical Condition: _____

Parent Consent for Student Self Management of Care

I, as parent/guardian, concur with the provided management plan, will provide the necessary supplies and equipment, notify the school nurse if there is any change in my child's health status or doctor's orders, and authorize the school nurse to contact the physician when necessary.

- ☐ I request that my child's medication be kept in the nurse's office.
- ☐ I give permission for my child to self-administer medication as prescribed by their physician and/or as written in their Emergency Action Plan or Individualized Healthcare Plan. This self management plan will be in effect until rescinded by either party.
 - ☐ I hereby certify that my child has been fully instructed and is capable of self-administration of the medication. I consent to my child carrying, storing and self-administering the medication at school. I acknowledge that I am responsible for providing my child with the medication, properly labeled from the pharmacy, and that I am responsible for any and all monitoring of my child's use of the medication and for any and all consequences of my child's self-administration of medication at school. I will indemnify and hold harmless Grand Island Public Schools, its employees and agents, against any and all claims arising out of my child's self-administration of medication at school, or at a school-related event.

Parent/Guardian Signature

Date

Student Consent for Self Management of Care

I will not share or allow other students to handle my medications or supplies.
I will notify the school nurse or other designated adult when I use my medication.
I will present to the nurse's office or designated adult if further medical care is needed.

Student Signature

Date