



# DORCHESTER SCHOOL DISTRICT TWO 2026-2027 DIABETES MANAGEMENT REQUEST FORM

**INTERNAL USE ONLY:**

- Med Received/Labeled
- Supplies Received
- Orders Entered into SNAP
- ICD-10/Billable Time
- Order Scanned into SNAP (3)
- Condition Entered
- IHP Created
- EAP Created

The following is to be completed by a parent/guardian & must accompany the diabetes order set from MUSC or another legal prescriber.

Name of Student: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade \_\_\_\_\_

**Medications/Supplies:**  Insulin – Type: \_\_\_\_\_  Hypoglycemia Medication – Type: \_\_\_\_\_

By signing this form, I acknowledge that Dorchester District Two cannot properly treat my student without all medications and supplies prescribed on the accompanying order set. These supplies and medications include, but are not limited to:

- Insulin (via injection or pump) and pen needles
- Glucometer, Lancets, Test Strips
- Ketone Test Strips
- Extra CGM and/or Insulin Pump supplies
- Rescue medication for hypoglycemia
- Glucose gel, glucose tabs, and/or snacks

**Transportation**  Car rider  Bus rider  Student driver

**Extracurricular Activities:**  LEAP  Athletics – Type: \_\_\_\_\_  Clubs – Type: \_\_\_\_\_

**Devices/Technology:**  Insulin Pump – Brand: \_\_\_\_\_  CGM – Brand: \_\_\_\_\_

**INSULIN PUMP:** I would like the pump placed in exercise/activity mode as needed for physical activity

My child has a smartphone for use with devices  My child has a Bluetooth receiver only for use with devices

**CGM:** would like my child’s CGM readings **used for information only** - OR -

If this box is checked\*\*, CGM readings may be used **for all instances of blood glucose monitoring as ordered by the prescriber** and finger sticks do not need to be used unless my student is symptomatic, outside of normal range, or device failure is suspected (per accompanying order set from prescriber)

*\*\*By checking the box above and signing this form below, I am requesting that Dorchester School District Two, with consent from the treating physician reflected in the accompanying orders, dose Insulin and other prescribed medication based on **CGM READINGS ONLY**. I acknowledge and agree that Dorchester School District Two does NOT have control of the placement, calibration, maintenance, or accuracy of the CGM. I understand that inaccurate placement, calibration, maintenance, or malfunction of the CGM could result in inaccurate glucose readings. Such inaccurate readings could result in erroneous dosing of Insulin and other prescribed medication. I understand that erroneous or inaccurate dosing of Insulin or other prescribed medications carry significant risks of illness, injury, and even death. By signing this Agreement, I acknowledge that I understand the risks related to dosing of Insulin or other prescribed medication based off CGM readings only. I voluntarily assume the risk of allowing my child to receive Insulin and other prescribed medication based on CGM readings only. I voluntarily agree to assume all risks and accept sole responsibility for any injury or illness, up to and including permanent disability or death, for my child based on this request. On behalf of myself, my child, and any successor guardian of my child, I hereby release, covenant not to sue, and agree to hold harmless Dorchester School District Two, administrators, Board of Trustees, nurses, and all other individuals employed by Dorchester School District Two for any and all claims, liabilities, damages, costs or expenses, related to any injury or illness resulting from Dorchester School District Two’s dosing of Insulin or other prescribed medication based off the CGM readings ONLY. By signing this Agreement, I acknowledge that I have read the foregoing fully & understand the contents of the Agreement. **I acknowledge the risks associated with dosing Insulin or other prescribed medications off CGM readings only and request that Dorchester School District Two dose & administer Insulin & other prescribed medication off CGM readings only.** I understand that in an emergency or in the case of an obvious failure of the CGM, a fingerstick may be used.*

1. I, the undersigned, ask that the above diabetic medications/treatments be administered to my child as directed and hereby release everyone participating in this request from any and all liability associated therewith or stemming therefrom.
2. Students will not share any prescriptions or diabetic supplies with another student. Violations may result in disciplinary action including, but not limited to suspension or expulsion.
3. I understand that the School Nurse/designees must follow ONLY the prescriber orders and no modifications to treatment, including Insulin dosing or carbohydrate ratios, can be made at student or parent request without prescriber orders.
4. I understand that it is the responsibility of the parent/guardian and student to ensure that the School has all necessary supplies and medications available to carry out the attached Diabetes order set. I understand that the use, replacement, and disposal of all supplies will be done following manufacturer guidelines.
5. I ask that my child be permitted to carry and use a Bluetooth receiver and/or cellular device for the purpose of diabetes monitoring.
6. I understand that in the event of a carrier or district network outage, cellular and Bluetooth devices may not be operational and my child’s diabetic orders may be carried out without the use of CGM or other devices.
7. In some circumstances it may be possible for the School Nurse to also follow CGM readings via a school-provided device in the health room. These readings will be **for information only** and will not replace monitoring per the providers’ orders attached. I understand that if I would like the Nurse to follow my child’s device, I will need to request this and provide necessary access. DD2 does not guarantee the availability of a device in the health room.

\_\_\_\_\_  
Name of Parent/Legal Guardian

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date