Escambia County Public Schools, Health Services, 30 E. Texar Dr. Pensacola, FL 32503 (850) 469-5456

Diabetes Self-Management Waiver and Agreement

School Year: _____
School:_____

Student Name:_____ Student ID #: _____ DOB: _____

This form must be completed annually and submitted with the current school year's Authorization for Diabetes Management Form. The Authorization for Diabetes Management Form must be signed by both the parent/guardian and the student's physician. The physician must indicate approval for self-management by selecting the appropriate Self-Care authorization.

Students may not carry insulin vials, insulin pens, or other diabetes medications unless specifically authorized by the physician on the Authorization for Diabetes Management Form.

Parent/Guardian Acknowledgment and Request

By signing below, I acknowledge and agree to the following:

1. I am requesting that my child be permitted to independently perform diabetes self-management tasks during the school day.
2. I believe my child possesses the knowledge, judgment, and skills necessary to safely and effectively manage their diabetes while at school.
3. I understand that my child may seek assistance from trained school health personnel at any time during the school day and that assistance will be provided as appropriate.
4. I understand that insulin vials and insulin pens may only be carried by my child if authorized by the physician. If authorization is not provided, all insulin supplies must be stored in the school clinic and administered in accordance with school procedures.
5. I understand that my child will be provided with a diabetic binder that they will document independently when insulin is self-administered in the clinic.
6. I understand that all medications and diabetic supplies that are not authorized for student self-carry must be delivered to the school clinic by a parent/guardian or other responsible adult in accordance with district medication policies.
7. I understand that school personnel are not responsible for making diabetes management decisions on behalf of my child when my child is independently performing authorized self-care activities.
8. I acknowledge that I remain responsible for ensuring my child is properly trained in diabetes self-management and for providing current medical orders and supplies necessary for my child's care.

In lieu of diabetes care being provided by delegated school personnel, I, _____, as the parent/legal guardian of _____, request that my child be permitted to independently perform authorized diabetes self-management activities during the school day. I understand that this authorization is contingent upon physician approval and school approval, may be revoked if my child demonstrates an inability to safely self-manage their diabetes, and must be renewed annually.

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I acknowledge that I am responsible for ensuring my child has the knowledge, skills, and supplies necessary to safely perform diabetes self-management activities at school.

_____	_____	_____
Parent/Guardian Print Name	Parent/Guardian Signature	Date

Student:

I understand my responsibilities related to diabetes self-management and agree to follow my physician's orders and school procedures.

_____	_____	_____
Student Print Name	Student Signature	Date

Staff:

_____	_____	_____
Clinic Staff Print Name	Clinic Staff Sign/Title	Date

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