Vantage Career Center
Diabetes Waiver Form

Permission to Self-Carry and Self Administer Diabetes Care:

To be completed by physician/provider, parent/guardian and student. This form is required by the District to serve to inform staff of expectations and responsibilities.

Student Name: _____ **Birthdate:** _____

Physician Section:

Student's physician/nurse practitioner confirms that the student has a diagnosis of diabetes, is independent and can perform diabetes care, and has approval to self-administer his/her diabetes care including: glucose monitoring, insulin calculation and administration. The student understands that he/she is to promptly report to the school nurse or adult as soon as the symptoms of high or low blood glucose appear or when not feeling well. I agree to prepare a written Diabetes Medical Management Plan in consultation with student's parents and appropriate school personnel.

Duration of order: 20____ 20____ School Year

Physician/Provider Signature: _____ **Date:** _____

Provider Printed Name: _____

Office Phone: _____ **Office Fax:** _____

Parent Section:

My child has been instructed and understands his/her diabetic self-management. My child understands that he/she is responsible and accountable for carrying and using his/her medication and equipment properly, including disposing of sharps in an appropriate container and participating in a form of documentation that would easily be accessible to the School Nurse and/or school staff if an emergency situation would occur. It is my understanding, school medication forms will need to be completed for all use of a communication device (cell phone, Dexcom, etc.). It is my understanding designated school employees will have access to the device at all times to monitor the safety and care of my child. The school will call 911 if child is found to be severely symptomatic of hyper, hypoglycemic states and/or found unconscious.

**** If child needs to administer insulin via needles, it must be done in the office due to blood borne pathogen exposure risk.**

I will provide the school nurse/school administrator with a copy of my child's Diabetes Medical Management Plan signed by his/her physician. I hereby give permission for the school to administer the medications as prescribed in the care plan, if indicated (student requests assistance or becomes unable to perform self-care). I also give permission for the school to contact the above physician/nurse practitioner regarding my child's diabetes care. I will not hold the school board or any of its employees liable for any negative outcomes resulting from the self-administration of diabetes medication by my child. I understand that the school nurse, after consultation with the parent/guardian and school administrator, may impose reasonable limitations or restrictions upon my child's possession and self-administration of diabetes medications relative to his/her age and maturity or other relevant considerations. I understand that the school administration may revoke permission to possess and self-administer said diabetes medication at any point during the school year if it is determined that my child has abused the privilege of possession and self-administration or he/she is not safely and effectively self-administering the medication. In addition, my child could be subject to further disciplinary action if equipment/device/medication is not used solely for intended individual.

Parent/Guardian Signature: _____ **Date:** _____

Student Signature: _____ **Date:** _____