Dublin City School District

Consent for Diabetic Management

Student's name: _____ **Birthdate:** _____ **School/Grade/Teacher:** _____

Prescriber's name: _____ **Prescriber's number:** _____

- The student's Ohio licensed health care prescriber's orders must accompany this form before administration at school is permitted.
- Parent/guardian must complete the appropriate section of this form before administration at school is permitted.
- This completed form must be on file in the student's health record.
- By signing any of the sections below, I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers as necessary for medical management.

Please check ONE of the following with regard to a student's independent functioning:

_____ This student is fully instructed and capable of independently counting carbohydrates, calculating corrections based on the blood glucose, determining insulin boluses and self-administering insulin via his/her insulin pump.

_____ This student will require supervision or assistance with: ☐ BG checks, ☐ carbohydrate counts, ☐ calculating insulin bolus, ☐ interventions, ☐ corrections, ☐ administration of insulin.

Request for Administration of Insulin via Dial Up Insulin Pen by School Personnel or Independently by Student

I hereby request and give my permission for school district personnel to administer or for staff to assist in monitoring the self-administration of prescribed insulin to my child in accordance with the specific written orders from our medical provider. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

I am responsible for the delivery of the insulin, insulin pen, needles, and other supplies to the school clinic and will notify the school immediately if we change our medical provider or the need for an insulin pen is terminated.

I agree to submit revised written orders from our medical provider if any changes are made regarding the above medication.

I understand this medication may be self-administered by my child; however, if school staff are administering insulin, it can only be administered to my child by a school nurse or myself until medically unlicensed staff in my child's school have completed the required District training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff is authorized to perform this task.

Parent/Guardian signature: _____ Date: _____

Home address: _____ Daytime phone: _____

Request for Student to Self-Administer Insulin via an Insulin Pump

I hereby authorize the provision of medically prescribed treatment of my child's diabetes in accordance with the specific written orders from our medical provider. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

I understand I must furnish all the necessary equipment, supplies, and medication for my child's insulin pump. I understand that school staff is not able to determine the carbohydrate counts or portions of my child's lunch and that if he/she requires assistance I will either provide the lunch carbohydrate count to the school each day or will be called to determine or verify the carbohydrate count and insulin dose for my child.

I agree to submit revised written orders from our medical provider if any changes are made regarding the above medication.

I understand that this request entails special circumstances justifying an exception from the usual procedures for administration of medication at school by school personnel.

Parent/Guardian signature: _____ Date: _____

Home address: _____ Daytime phone: _____

Request for Administration of Glucagon Injection by School Personnel

I hereby request and give my permission for school district personnel to administer the prescribed Glucagon to my child in accordance with the specific written orders from our medical provider. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

I am responsible for the delivery of the Glucagon to the school clinic and will notify the school immediately if we change our medical provider or the need for Glucagon is terminated.

The Glucagon I have brought to school expires on: _____.

I agree to submit revised written orders from our medical provider if any changes are made regarding the above medication.

I understand this medication can only be administered to my child by a school nurse or myself until medically unlicensed staff in my child's school have completed the required District training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff is authorized to perform this task and 911 will be called whenever Glucagon is given.

I agree to provide a separate dose of Glucagon to school staff supervising my child's extracurricular activities.

Parent/Guardian signature: _____ Date: _____

Home address: _____ Daytime phone: _____

Medication Intake / Sign Out

Date	Time	Quantity	Initials		Event Description - list INTAKE or SIGN OUT AND additional details (i.e., field trip, med request, med error, wasted etc)	Date Returned	Time Returned	Quantity Returned	Initials Returned	

Month	AUG		SEPT		OCT		NOV		DEC		JAN		FEB		MAR		APR		MAY		JUN	
Discrepancy	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Initials																						

Disposal Directions:
All meds should be returned to parent/guardian of appropriate student. If multiple attempts were made unsuccessfully, please complete the following procedure.
All non-controlled medications should be disposed of in sharpes container in the presence of the building administrator or SRO.
All controlled medications should be disposed of in the community prescription drug drop box located in the lobby of the Dublin Justice Center, 6565 Commerce Parkway.
All controlled medication must be disposed of in the presence of two (2) staff members, one of which must be the SRO or an administrator. Both signatures are required.

Date	Medication	Dose	Qty	Manner of disposal	Signature	Signature
_____	_____	_____	_____	_____	_____	_____