Administrative Form HEA-F110

INDEPENDENT DIABETES CONSENT AND REQUEST

Student Health Services Department

FAX: (775) 353-5968

Date: _____

STUDENT NAME: _____DOB:_____SCHOOL: _____

Diabetes Mellitus ☐ Type I ☐ Type II

☐ This student is independent in self-managing all aspects of his/ her diabetes care, including self-administration of medication, and does not need supervision or assistance from school personnel.

LICENSED HEALTH CARE PROVIDER PLAN OF CARE FOR STUDENT TO FOLLOW FOR SELF-MANAGEMENT OF DIABETES WHILE AT SCHOOL:

☒ Check blood glucose

☒ If blood glucose below _____, consume 15 to 30 grams fast-acting carbohydrate

☒ If blood glucose remains below ____ after 10-15 minutes, request adult escort to the school health office.

Other: _____

☒ If blood glucose above _____, check ketones and drink 12 to 24 oz. water.

☒ If moderate ketones present and blood glucose above 300, request adult escort to school health office.

☒ If symptoms persist or become worse, request adult escort to the school health office.

☐ Administer _____ medication via ☐ pump ☐ insulin pen ☐ syringe as directed by your licensed health care provider.

If pump, type of pump _____Other diabetes medications prescribed _____

Other orders/Directives_____

Licensed Health Care Provider Signature_____ Date: _____

THE FOLLOWING EMERGENCY INTERVENTIONS AND 911 WILL BE IMPLEMENTED BY SCHOOL PERSONNEL AS FOLLOWS:

IF student semi-conscious, unconscious, or unable to swallow, school personnel to begin standard emergency procedures and activate school's code blue plan while 911 is in route.

IF student reports moderate to severe diabetes symptoms, have them check blood glucose; if blood glucose below 75 and able to swallow, he/she will be encouraged to consume fast-acting carbohydrate while school's code blue plan is activated and 911 is in route.

Consent and Request for Student to Self-Manage Diabetes Care, Including Administration of Medication

The undersigned parent or guardian verifies that the above named student is capable of self-managing all aspects or his/her diabetes care, including administration of medication without assistance or supervision, and hereby requests the Washoe County School District ("WCSD") to allow the above named student to self-manage all aspects of the student's diabetes care, including administration of medication, while the student is present on a WCSD campus, during WCSD transportation, and while participating in school-sponsored activities. The undersigned parent or guardian hereby acknowledges that the

STUDENT NAME: _____DOB:_____

above provisions do not create a duty for the Board of Trustees of the WCSD, the WCSD, the school in which the student is enrolled, or employees and agents of the District, in addition to those duties otherwise required in the course of service or employment.

In addition, the parent or guardian hereby gives permission to the school nurse at the above described WCSD school to exchange confidential information, if needed regarding the student's diabetes care and/or medication, with the undersigned health care provider or physician; and further hereby agrees assume all risk and responsibility regarding the student's diabetes care or medication and to defend and hold the Washoe County School District, the Board of Trustees of the District, and all employees and agents of the District harmless from and all losses or liability, claims or expenses, including any and all claims for contribution or indemnity by any party for their participation in allowing the above named student to self-managing his or her diabetes care, including administration of medication.

The undersigned parent or guardian hereby agrees to provide the student with all diabetes medication, supplies, and equipment required in order for the student to carry out diabetes care independently while the student is present on a WCSD campus, during WCSD transportation, and while participating in school-sponsored activities and the undersigned parent or guardian agrees to assume all responsibility for maintaining the supply of the medication, supplies and equipment, replacing such medication supplies and equipment when its effectiveness has lapsed by reason of time.

The undersigned parent or guardian hereby acknowledges that authorization of the student to self-administer medication may be revoked at any time if the student fails to comply with "Nursing Services for Students with Diabetes" (HEA-P102).

I am in agreement with the orders set forth as stated above:

Parent/Guardian Name (please print)_____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

Health Care Provider Name (please print)_____

PHONE _____ FAX _____

Health Care Provider Signature: _____Date: _____

SCHOOL NURSE VERIFICATION AND SIGNATURE

I, the undersigned school nurse, verify that the parent/guardian has been provided with a copy of the Student Health Services diabetes policy, "Nursing Services for Students with Diabetes" (HEA-P102). I further verify that I have met with the student to review and ensure understanding of the above "Diabetes Treatment Plan for Student's Self-Management of Diabetes Symptoms" and the WCSD protocols for containing blood borne pathogens and the handling and disposal of needles, medical devices, and other medical waste and have provided a copy of these protocols and procedures to the parent or guardian of the student.

School Nurse Name/Title (please print)_____

School Nurse Signature: _____ Date: _____

THIS ORDER AND REQUEST EXPIRES AT THE END OF THE SCHOOL YEAR