PARKWAY SCHOOL DISTRICT
PERMISSION FOR STUDENT TO SELF-MANAGE DIABETES CARE FOR SCHOOL YEAR _____

Student's Full Name_____Date of Birth _____Grade_____

Parent/Guardian Name & Phone Number(s) _____

Emergency Contact & Phone Number(s) _____

To be Completed by Parent/ Guardian

I hereby certify the following:

_____, am the parent or legal guardian of_____ ("Student"), a student in the Parkway School District ("District"), and am legally authorized to make educational and health care decisions for the Student.

- I hereby give my permission for the Student to retain in his/her possession of the necessary items to perform blood glucose checks, administer insulin through the student's insulin delivery systems, treat hypoglycemia and hyperglycemia, and otherwise attend to the care and management of the student's diabetes.
  and otherwise attend to the care and management of the student's diabetes.
- This permission shall be effective during the school day; on school property, including but not limited to a school bus; and at all school activities, whether on or off school property or occurring during the regular school day.
- I have provided the District with a written medical history of the Student's experience with diabetes and a plan of action for addressing any emergency situations that could reasonably be anticipated as a consequence of administering the medication and having the Condition.
- I have provided the District with written certification from the Student's physician, stating that the Student (a) has the aforementioned Condition and (b) is capable of, and has been instructed in, the proper method of self -administration of medication and informed of the dangers of permitting other persons to use the medicine prescribed for the Student.
- I understand that the District and its employees or agents may disclose information provided in accordance with the foregoing paragraphs to administrators, school nurses, teachers, and other school employees as may be necessary to protect the health of the Student and to establish that the Student has been authorized to self-administer medication. and shall incur no liability for the disclosure of such information.
- I understand that the District and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by the Student, and that I shall be required to indemnify and hold harmless the District and its employees or agents against any claims arising out of the self-administration of medication by the Student.
- I understand that this permission form is effective for the school year for which it is granted, and that a new Permission Form and supporting documentation as described above, must be submitted for each school year.
- I agree to supervise that my child carries his/her necessary supplies and medication.
- It has been recommended to me that a back-up supplies be provided to the Health Office for emergencies.
- I have been advised that is is required to provide a complete diabetes medical management plan from our physician.
- I will review the status of my student's diabetes with my student on a regular basis.
- My student will ☐regularly carry his/her supplies ☐carry supplies to the track and/or on field trips☐ carry to transport medication and supplies to/from school.

Signature of Parent/Guardian _____Date _____

To be Completed by Physician

Physician's Name _____ Phone_____Fax _____

Medication Name _____ Dose_____

Diagnosis _____

☐ Student's physician or licensed 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 (including pump operation & pump equipment)

☐ The student understands that he/she is to promptly report to the school nurse or adult as soon as 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. Physician's Signature_____Date_____

Approved by School Nurse ☐Yes ☐No Signature _____

Date _____