Oxford Area School District
Authorization for Self Management of Diabetic Care

PHYSICIAN/PRESCRIBING HEALTH CARE PRVIDER ORDER

_____ Orders attached (if orders are attached; only your signature is required)
_____ Treatment hyperglycemia_____
_____ Treatment of hypoglycemia_____
_____ Glucagon order _____
_____ Carb-Insulin ratio (if applicable)_____
_____ Insulin Sliding Scale (if applicable) _____

In my opinion, this student shows the capability of independent self management of diabetic care while at school or school event.

_____ _____ _____ _____
Physician Signature Print Name Telephone Date

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named about, be permitted to self manage diabetic care independent of the school health room. I am aware that a daily log of blood glucose numbers will not be kept in the health room. I take responsibility for this permission.

_____ _____
Parent/Guardian Signature Date

STUDENT CONTRACT

Responsibility for self management of diabetic care.

_____ Verbalizes knowledge of physician orders.
_____ Verbalized knowledge of hypo and hyperglycemia and treatment of both.
_____ Demonstrates blood glucose testing and insulin coverage as indicated.
_____ Verbalized knowledge of universal precautions.
_____ Extra supplies in health room.
_____ Agrees to make contact with nurse at least once a month.
_____ Agrees to come to health room if blood sugar does not respond to insulin as expected or with any other concerns/problems.

_____ _____
Student Signature Date

We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or if there is a safety risk. We will contact the parent/guardian as soon as possible in this event.

_____ _____ _____ _____
Nurse Signature Date Principal Signature Date