CENTRAL BUCKS
SCHOOL DISTRICT

Physician and Parent Authorization for Student Self-Administration of Diabetes Treatment

_____ _____

Student/Patient Name Date form completed

Section 1. *To be completed by the **Physician**.*

The above student is a patient under my care for diabetes type ___ .

This student is competent to self-administer the following medication or monitoring equipment and is able to practice proper safety precautions for the handling and disposal of such medication and monitoring equipment:

☐ He or she is authorized to self-monitor his or her blood glucose levels to ensure maintenance of levels within the range of _____ mg/dL and _____ mg/dL, using the following equipment at the following times or under the following conditions:

Equipment authorized: _____

Times of day or conditions when self-monitoring is required:

_____

_____

_____

☐ He or she is authorized to self-administer the following medications:

☐ Insulin type(s): _____

Device used for administration: _____

For correction of hyperglycemia: _____ unit(s) for every _____ mg/dL over _____ mg/dL

For coverage of carbohydrate intake: _____ unit(s) for every _____ g. of carbohydrate

Other: _____

Potential serious reactions: _____

Necessary emergency response:

_____

_____

_____

☐ Other Medication: _____ For: _____

When: _____ Dosage: _____

Potential serious reactions: _____

Necessary emergency response: _____

_____

_____

This authorization to self-administer the foregoing medication(s) or monitoring equipment and to practice proper safety precautions for the handling and disposal of such medication and monitoring equipment shall remain in full force and effect, unless revoked in writing by me, through _____.

_____

Signature of Physician Printed Name License Number

Section 2. *To be completed by the* ***Parent or Guardian***.

I(we)/am(are) the parent(s) or guardian(s) of the above student and hereby authorize the Central Bucks School District to comply with the self-administration instructions of my(our) child's health care practitioner outlined herein. I(we) release the Central Bucks School District and any of its employees or agents from any responsibility or liability for the use, possession, or distribution of the prescribed medication or monitoring equipment and acknowledge that the school entity bears no responsibility for ensuring that the medication is taken by the student or that the monitoring equipment is used. I(we) have read the authorization of the health care practitioner contained herein and understand fully the authorizations, releases, and acknowledgements I(we) am(are) providing by signing this document.

Signature of Parent or Guardian Printed Name Date

Signature of Parent or Guardian Printed Name Date

Section 3. *To be completed by the* ***Student***.

I have received instruction from my health care practitioner on the use of, and the proper safety precautions for the handling and disposal of, the medications and monitoring equipment described above. I will not allow other students to have access to the medication, injection materials and monitoring equipment, and I understand the safeguards about which I have received instruction.

Signature of Student Printed Name Date