KEARNEY SCHOOL DISTRICT
Pursuing Excellence Today for Tomorrow

AUTHORIZATION FOR STUDENT TO SELF-CARE FOR DIABETES

6-12th GRADES ONLY

Student Name:______________________________________ **Grade:**__________________________

Medication(s) and supplies to self-carry:____

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According to Missouri Law, students may be allowed to carry and self-administer prescribed diabetes medication and carry needed equipment and supplies for diabetes self-care while at school, at a school-sponsored activity and in transit to or from school or school-sponsored activity when they meet the following requirements:

- A physician prescribed the medication for use by the student and instructed the student in the correct and responsible usage of the medication and equipment.
- The student has demonstrated to the student's licensed physician or the licensed physician's designee, and the school nurse the skill level necessary to use the medication and any device necessary to administer such medication prescribed or ordered.
- The student's physician has approved and signed a written treatment plan for managing the student's chronic health condition, including asthma, diabetes or anaphylaxis episodes and for medication for use by the student. Such plan shall include a statement that the student is capable of self-administering the medication under the treatment plan. The plan may be effective only for the same school year it is granted and must be renewed each year.
- The student's parent/guardian has completed and submitted to the school any written documentation required by the school, including the treatment plan and a liability statement acknowledging the school district and its employees shall incur no liability as a result of any injury arising from the self-administration of medication by the student.

PHYSICIAN STATEMENT FOR STUDENT TO SELF-ADMINISTER QUICK-RELIEF MEDICATION:

I certify that the above named student has a medical history of diabetes, has been instructed in the proper self-administration of the medications(s) and equipment listed above and is judged to be capable of carrying and self-administering the medication(s) and performing self-care tasks required for diabetes management. The student has been instructed to notify or have someone notify the school nurse if any signs or symptoms of hard to control blood glucose levels occur. This student understands the hazards of sharing medications with others and has agreed to refrain from the practice. I have provided a written diabetes treatment plan for the student to follow and provide a copy to the school.

Physician Signature:___________________________________ **Date:**_____________________

PARENT/GUARDIAN STATEMENT FOR STUDENT TO SELF-ADMINISTER MEDICATION:

I, the parent/guardian of the above named student, give permission for this student to carry and self-administer the above listed medication(s) and independently perform the necessary actions needed for diabetes self-care. I have reinforced that my student should notify the school nurse if signs or symptoms of hard to control blood glucose levels occur. I acknowledge that the school district and its employees shall incur no liability as a result of any injury arising from the self-administration of medication or diabetes self-care by my student.

Parent Signature:___________________________________ **Date:**_____________________

Responsibilities for carrying Inhalers: (to be verified by the School Nurse)

☐Yes ☐No Student is able to identify signs and symptoms of hyper and hypoglycemia
☐Yes ☐No Student agrees to come directly to Health Room when having difficulty regulating blood glucose levels
☐Yes ☐No Student demonstrates proper self-administration technique to ensure good delivery of insulin
☐Yes ☐No Student has diabetic supplies in Health Room for backup (recommended, not required)
☐Yes ☐No Student knows that any medication carried must have prescription label attached to identify medication's owner

School Nurse Signature:___________________________________ **Date:**____________________