

Bay City Public Schools

Self-Administered Medication Authorization Form —Insulin and Blood Glucose Monitoring (If approved by Physician and Parent) **(Med-4)**

Students may care for their diabetes at school wherever and whenever it is necessary. Self-administration means that the student may manage their diabetes in a manner directed by the physician without additional direction or supervision of school staff. Self-possession means that under the direction of the physician, the student may carry insulin and/or equipment necessary to manage their diabetes on her/his person to allow for immediate and self-determined administration. Spare glucose monitoring equipment and insulin with prescription label, may be kept in the office in case of emergency or if the student runs out/forgets the medication.

Student Name _____ Birthdate _____ Teacher/Counselor _____ Grade _____ School Year _____

To be completed by physician/licensed prescriber:

	<u>Type of Insulin</u> (with prescription label)	<u>Dose</u>	<u>Time To be Given</u>	<u>Storage</u>	<u>Activity Modification</u>	<u>Scheduled Snack</u>
				___Transported daily ___Carried by student	___Yes _____No	___Yes _____No
				___Stored at School ___Needs refrigeration	Explain: (i.e., rest, snack, etc.)	Time:
						Type:
	<u>Regular Blood Glucose Monitoring</u> (Blood Sugar Checks)	<u>Equipment Needed</u>	<u>Transported Daily</u> Yes No	<u>Stored At School</u> Carried Yes No By student		
	<u>AM Time</u> <u>PM Time</u>					
	Special Instructions:					

Signs/Symptoms of insulin reaction (low blood sugar) needing emergency care: Pallor, sweating, trembling, headachae, blurred vision, student reports “having a reaction.” In the event of an insulin reaction, the procedure routinely followed at school is to give some form of sugar such as 4 oz. of milk followed with crackers and peanut butter, 4 oz. Fruit juice or 4 oz. Non-diet soda. If student is unconscious, “911” is called. Parents are contacted for all reactions.

Other symptoms specific to this student: _____

Please list other special instructions: _____

Parent-supplied emergency items to be left at school: ()Glucose tablets ()Snacks ()Syringes ()Blood glucose meter ()Insulin ()Other _____

Other Health Concerns: _____

Start date: _____ Stop date: _____

Student is capable of: ()self possessing diabetic management equipment/insulin ()self-monitoring blood glucose levels ()self-administering insulin wherever and whenever needed at school or on school property.

Physician’s Printed Name: _____ Physician’s Phone #: _____ Physician’s Fax #: _____

Physician’s Signature: _____ Physician’s Address _____ Date: _____

To be completed by parent/guardian:

I request and give permission for (name of child) _____ to ()self-monitor blood glucose levels, ()self-administer diabetic insulin, and ()self-possess insulin and equipment for monitoring blood glucose levels at school according to standard school district policy and for the physician’s staff and school personnel to share relevant information regarding my child’s medication needs.

Parent/Guardian Signature _____ Date _____

Student Name: _____

To be completed by student and parent/guardian

I agree to:

1. Never share my medication with another person.
2. Carry the medication in its original properly labeled prescriptive/over-the-counter container.

I am knowledgeable about self-monitoring my blood glucose levels, self-administering insulin in the prescribed dose or in dosage indicated by blood glucose levels, and that I am capable of self-possessing equipment necessary to manage my diabetes condition. I also understand the desired effects, side effects, administration, etc. of the medication(s), and that if I do not comply with this agreement, the privilege of self-administration/self-possession will be reassessed.

Student Signature: _____ Date _____

ParentGuardian Signature: _____ Date _____

Note: Parent must also complete the Parental Request Form.