RENWICK USD 267

DIABETES SELF-MANAGEMENT FORM

I request that my child, ___________________________________, be permitted to self-medicate at school. I request that my child be permitted to carry the medication with him/her. I understand my child will be responsible for knowing the location of the medications at all times. The school district and its officers, employees or agents incur no liability for damage, injury or death resulting directly or indirectly from this request to self-medicate. I have read the medication policy for Renwick USD 267 (Board Policy JGFGB, JGFGBB and JGFGBA).

The student has demonstrated the skill level necessary to use the medication as prescribed. I have discussed the following conditions with my child:

1. Immediately tell an adult when having a diabetic emergency.
2. Never share medication with anyone else.
3. Have a prescription label on medication or write student name on insulin and diabetic supply bag.

Student's Name____ D.O.B. _____________________
Grade/Teacher ____ School _____________________

Medication(s) & Dosage(s)____
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____
____

Physician Signature ____ Date ___________________________

Physician printed name_______________________________________ Phone __________________________

Parent or Guardian Signature__________________________________ Date ____________________________

NOTE: All medications are to be brought to school in the original container appropriately labeled by the pharmacy or physician, stating the name of the medication, dosage and time to be administered.