East Stroudsburg Area School District
Authorization for Diabetes Self-Management

(Student is to carry a copy of this document with them at all times. Original on file in the nurse's office)

Date: ___________________________

Student Name: ________________________________ DOB _____________Grade: _______

___ Student is independent in in self care of blood glucose monitoring.
___ Student recognizes signs and symptoms of hypo/hyperglycemia.
___ Student is independent in calculating carbohydrates.
___ Student is independent in self - care of insulin administration.
___ Student is independent in self - care of the insulin pump, if applicable
___ Student is knowledgeable and capable of practicing proper safety precautions
___ Student is independent in self care of blood glucose prior to physical activity.
___ Student knows how to properly store/handle their insulin and other diabetic equipment.
___ Student knows how to dispose of any "sharps" equipment in a safe and proper manner
___ **Most importantly student knows when to seek help from medical staff.**

In my opinion, this student shows the capability to self-manage their diabetes in school.

Health Care Provider's Signature ______________________________________Date __________

Health Care Provider's Printed Name ____

I the parent/legal guardian of the above student request that the ESASD comply with the instructions of my student's health care provider and allow my student the privilege to self manage their diabetes care during the school day, on the bus and for field trips. I the parent/legal guardian accept that the ESASD bears no responsibility for ensuring that the medication is taken by the student and the monitoring equipment is used, and bears no legal responsibility should the medication or monitoring equipment be lost, given to or taken by a person other than the above student. **I the parent/ legal guardian will provide a sharps container for my student to dispose of "sharps" during the school day, on the bus and during field trips.**

Parent/Legal Guardian Signature ____________________________________ Date _________

-I have been instructed in and am independent in the self care and management of my diabetes. I have been instructed in the proper use of my prescription medication and monitoring equipment. I will use this medication and monitoring equipment as per my health care provider's orders. I will not share this medication or monitoring equipment under any circumstances. I understand that self management of my diabetes in school, on the bus and during field trips is a privilege and can be revoked. I will immediately report any lost/missing medication or equipment. I also agree to collaborate with the nurse and/or ESASD school physician, as needed, in the care of my diabetes. I will dispose of "sharps" equipment in a safe and proper manner.

Student's Signature __________________________________ Date _________________

ESASD accepts the primary health care provider's orders, student's statement, and parent/legal guardian's request. ESASD will permit the above named student to self manage their diabetes care in school. ESASD reserves the right to withdraw the privilege to self manage their diabetes at any time should the student shows signs of irresponsible behavior or if there is a safety risk.

Principal Signature ____________________________________ Date ________________

School Nurse Signature _________________________________ Date ________________