

DIABETES MEDICATION AND OPERATE MONITORING EQUIPMENT  
 SELF-ADMINISTRATION BY STUDENTS

\_\_\_\_\_ Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ Date

**This section to be completed by physician:**

**Student has permission to and is capable of self-administering diabetes medication and to operate monitoring equipment independently. Individual student health plan instructions are provided with this form.**

[ ] Yes [ ] No \_\_\_\_\_  
 (Physician Signature) (Date)

To self medicate, the student must be able to: (check all that apply)

- \_\_\_\_\_ 1. Respond to and visually recognize his/her name.
- \_\_\_\_\_ 2. Identify his/her medication.
- \_\_\_\_\_ 3. Demonstrate the proper technique for self-administering his/her medication and use of monitoring equipment.
- \_\_\_\_\_ 4. Sign his/her medication sheet to acknowledge having taken the medication.
- \_\_\_\_\_ 5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.

\_\_\_\_\_ Name of Insulin \_\_\_\_\_ Method of Delivery \_\_\_\_\_ Frequency

The above named student has demonstrated the ability to self-administer the physician-prescribed medication and operate the monitoring equipment as indicated by the criteria listed above.

\_\_\_\_\_ Date \_\_\_\_\_ Signature (Certified School Nurse)

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for the medication or monitoring equipment and for ensuring that the student takes the medication or uses the monitoring equipment. I am aware that any improper use/ sharing of the above named medication or monitoring equipment will result in the immediate confiscation of the medication or monitoring equipment and loss of privilege to self-administer if the medication policy is violated.

\_\_\_\_\_ Date \_\_\_\_\_ Parent/Guardian Signature

210.2. ATTACHMENT

I agree to be solely responsible for diabetes medication and monitoring equipment and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I have been trained by a health care practitioner in safety precautions for the handling and disposal of medications and monitoring equipment. I am aware that improper use/ sharing of the above named medication or monitoring equipment will result in the immediate confiscation of the medication or monitoring equipment and loss of privilege to self-administer.

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Date

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Student's Signature