Rowan Salisbury Schools
Diabetes Management Plan

Student: _____ Date of Birth: _____

EMERGENCY CONTACT INFORMATION

Name: Parent/Guardian: _____ Relationship: _____

Telephone: Home: _____Work: _____ Cell: _____

Name: Parent/Guardian: _____Relationship: _____

Telephone: Home: _____Work: _____ Cell: _____

Name: Other Contact: _____ Work: _____Cell: _____

Parent Authorization for Medication Administration, Specialized Health Care Procedures and Release of Information:

I, (parent/guardian) _____ give permission to the school nurse or another qualified health care professional or trained diabetes personnel of the Rowan Salisbury School System to perform and carry out the diabetes care tasks as outlined in this Diabetes Medical Management Plan. I also consent to the release of the information contained in the Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse to contact my child's physician/health care provider.
I understand that I am to provide all necessary supplies needed for my child's diabetes care. I understand that all insulin vials or insulin pen refills must be replaced on expiration and/or **every 30 days once opened**.

Immediate parent pick up will be required for students who do not have functioning equipment or supplies necessary to provide diabetes management.

The parent/guardian releases the School Board, its agents and employees, from any and all liability that may result from his/her child taking these prescription medications and/or receiving these specialized health care procedures and is aware that these orders expire no later than the last day of this school year.

Parent/Guardian Signature: _____ Date: _____

SELF MEDICATION ONLY

_____ I give permission for my child to care for his/her diabetes independently.
Parent/Guardian Initials