

**CONSENT FORM FOR GLUCOSE MONITORING AND
INSULIN SELF – ADMINISTRATION**
ICD CODE _____

Student Name: _____ Date of Birth: _____
School: _____ Grade: _____ Teacher: _____ Room #: _____
Parent/Guardian Name: _____ Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Licensed Prescriber: _____ Clinic: _____ Phone: _____
Hospital: _____ Phone: _____

Physician's Orders:

Self Management:

1. **Meal Plan:** Carb Counting Y / N Scheduled Snacks: Y / N Time: _____
2. **Blood Glucose Monitoring:** Meter Type: _____ Time of Testing: _____
Testing Independently: Y / N if no assist with Lancet? Y / N Assist with obtaining blood sample? Y / N
3. **Exercise Plan:** Extra Cars for PE days: Y / N Amount: _____

Insulin to be given as ordered. Insulin Regime: Sub-q _____ Pump _____ Pump type _____

Student may self-administer insulin at school: Y / N

Insulin Type:	Dose:	Time:	Delivery Method:
_____	_____	_____	_____
_____	_____	_____	_____

Correction Dose: _____ units of insulin for every _____ above _____ mg/dl

Student is able to self-adjust insulin: Y / N Comment: _____

Ketone Urine Check if blood glucose is above _____: Y / N **Glucagon PRN:** dose: _____

Licensed Prescriber's Signature: _____ **Date:** _____

Parental Release:

I, the parent/legal guardian request that glucose monitoring and insulin administration be administered as prescribed according to the licensed prescriber's orders. I would like to be notified under the following circumstances:

- _____ Severe low blood glucose reaction not responding to treatment within one-half hour
- _____ Blood glucose levels below _____
- _____ Blood glucose levels above _____
- _____ Other _____

I, the parent/legal guardian, understand that it is my responsibility to provide all required supplies for blood glucose monitoring as well as snacks and any/all items to be used in case of an insulin reaction.

I, the parent/legal guardian, release school personnel from any liability in relation to the administration of this procedure at school. If parent/legal guardian is not available during an emergency, the physician and/or ambulance may be called. I understand that any charges incurred are the responsibility of the parent/ guardian.

I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medial condition being treated by the medications(s).

The school nurse may share this information with appropriate school personnel _____ yes _____ no.

Parent/Guardian Signature: _____ **Date:** _____