Washoe County School District
STUDENT HEALTH SERVICES
(Fax 775-353-5968)

Student ID # _____

INDEPENDENT DIABETES CONSENT AND REQUEST

Date: _____

STUDENT NAME: _____**DOB:** _____**SCHOOL:** _____

Diabetes Mellitus ☐ **Type I** ☐ **Type II**

☐ This student is **independent in self-managing all aspects** of his/her diabetes care, including self-administration of medication, and **does not need supervision or assistance from school personnel.**

LICENSED HEALTH CARE PROVIDER PLAN OF CARE FOR STUDENT TO FOLLOW FOR SELF-MANAGEMENT OF DIABETES WHILE AT SCHOOL, PARTICIPATING IN A SCHOOL-SPONSORED ACTIVITY, OR ON A SCHOOL BUS:

☐ Check blood glucose

☐ If blood glucose below _____, consume 15 to 30 grams fast-acting carbohydrate

☐ If blood glucose remains below _____ after 10-15 minutes, request adult escort to the school health office.

Other: _____

☐ If blood glucose above _____, check ketones and drink 12 to 24 oz. water.

☐ If moderate ketones present and blood glucose above 300, request adult escort to school health office.

☐ If symptoms persist or become worse, request adult escort to the school health office.

☐ Administer _____ medication via ☐ pump ☐ insulin pen ☐ syringe as directed by your licensed health care provider.

If pump, type of pump _____ Other diabetes medications prescribed _____

Other orders/Directives_____

Licensed Health Care Provider Signature: _____**Date:** _____

* Licensed Health Care Provider's Order may be submitted in place of filling out the above form, so long as (1) the Order is signed by the Licensed Health Care Provider, (2) the Order indicates that the student has diabetes and is capable of self-administration of diabetes medicine/care, and (3) the Order provides a written treatment plan pursuant to which the **student** will manage his or her diabetes if the student experiences a diabetic episode.

UNLESS THE LICENSED HEALTH CARE PROVIDER'S ORDERS PROVIDE OTHERWISE, THE FOLLOWING EMERGENCY INTERVENTIONS AND 911 WILL BE IMPLEMENTED BY SCHOOL PERSONNEL AS FOLLOWS:

IF student semi-conscious, unconscious, or unable to swallow, school personnel to begin standard emergency procedures and activate school's code blue plan while 911 is in route. If student is wearing an insulin pump, place pump in suspend/stop mode or disconnect tubing from infusion site. Keep pump with student

IF student reports moderate to severe diabetes symptoms, have them check blood glucose; if blood glucose below 70 and able to swallow, he/she will be encouraged to consume fast-acting carbohydrate while school's MERT Teams is activated and 911 is in route.

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STUDENT HEALTH SERVICES
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Student ID # _____

STUDENT NAME: _____DOB: _____

Consent and Request for Student to Self-Manage Diabetes Care, Including Administration of Medication

The undersigned parent or guardian verifies that the above-named student is capable of self-managing all aspects of his/her diabetes care without assistance or supervision, and hereby requests the Washoe County School District to allow the above-named student to self-manage all aspects of the student's diabetes

care, including administration of medication, while the student is present on a WCSD campus, during WCSD transportation, and while participating in school-sponsored activities. The undersigned parent or guardian hereby acknowledges that the above provisions do not create a duty for the Board of Trustees of the WCSD, the WCSD, the

school in which the student is enrolled, or an employee or agent thereof, that is in addition to those duties otherwise required in the course of service or employment. Parent/Guardian Initials: _____

The parent or guardian hereby further acknowledges that if their student is granted authorization to self-administer medication/care for their diabetes, the Board of Trustees of the WCSD, the WCSD, the school in which the student is enrolled, or any employee or agent thereof, are immune from liability for any injury to or death of: (1) the student as a result of self-administration of a medication/care or failure of the student to self-administer such medication/care; and (2) any other person as a result of exposure to or injury caused by needles, medical devices, or other medical waste from the self-administration of medication/care by the student. Parent/Guardian Initials: _____

The parent or guardian hereby agrees to assume all risk and responsibility regarding the student's self-administration of diabetes medication/care and to defend and hold harmless the WCSD, the Board of Trustees of the WCSD, and all employees and agents thereof from all losses or liability, claims or expenses, including any and all claims for contribution or indemnity by any party for their participation in allowing the above-named student to self-managing his or her diabetes care. Parent/Guardian Initials: ____

In addition, the parent or guardian hereby gives permission to the school nurse at the above described WCSD school to exchange confidential information, if needed regarding the student's diabetes care and/or medication, with the student's Licensed Health Care Provider. Pursuant to NAC 632.220, as a condition of providing care for the purposes related to this form, a registered nurse may need to contact the licensed health care provider or associates regarding the verification of an order given for the care of a patient to ensure that it is appropriate and properly authorized and that there are no documented contraindication in the carrying of the order. Parent/Guardian Initials: _____

The undersigned parent or guardian hereby agrees to provide the student with all diabetes medication, supplies, and equipment required in order for the student to carry out diabetes care independently while the student is present on a WCSD campus, during WCSD transportation, and while participating in school-sponsored activities. The undersigned parent or guardian also agrees to assume all responsibility for maintaining the supply of the medication, supplies, and equipment, replacing such medication, supplies, and equipment when necessary. Parent/Guardian Initials: _____

The undersigned parent or guardian hereby acknowledges receipt of the District's "Infection Control Guidelines for Students Who Use Medical Devices on WCSD Property" (HEA-G1230) which contains protocols regarding blood-borne pathogens and the handling and disposal of needles, medical devices and other medical waste. In addition, the parent or guardian acknowledges that the District's "Infection Control Guidelines for Students Who Use Medical Devices on WCSD Property" (HEA-G1230) has been explained to the student who will self-administer medication/care and that the student has agreed to comply with these protocols. Furthermore, the parent or guardian acknowledges that authorization of the student to self-administer medication/care may be revoked at any time if the student fails to comply with the protocols established in the District's "Infection Control Guidelines for Students Who Use Medical Devices on WCSD Property" (HEA-G1230). Parent/Guardian Initials: _____

I am in agreement with the orders set forth as stated above:

Parent/Guardian Name (please print) _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

Licensed Health Care Provider's Name (please print) _____

PHONE _____ FAX _____

Health Care Provider Signature: _____Date: _____

SCHOOL NURSE VERIFICATION AND SIGNATURE

I, the undersigned school nurse, verify that the parent/guardian has been provided with a copy of the "Infection Control Guidelines for Students Who Use Medical Devices on WCSD Property" (HEA-G1230) and that I have met with the student who will self-administer medication/care to explain the District's protocols for containing blood borne pathogens and the handling and disposal of needles, medical devices, and other medical waste. I further verify that I have explained to the student that authorization to self-administer medication/care for diabetes may be revoked if the student fails to comply with the District's "Infection Control Guidelines for Students Who Use Medical Devices on WCD Property."

School Nurse Name/Title (please print) _____

School Nurse Signature: _____ Date: _____

THIS ORDER AND REQUEST EXPIRES AT THE END OF THE SCHOOL YEAR