Cincinnati Children's

Cincinnati Children's Diabetes Center
Self-Management Request for a Student with Diabetes

Student Name: _____ Date of Birth: _____ School Yr: _____

School Name and Address: _____ Grade: _____

School Nurse/Personnel: _____

School Phone: (_____)_____ School Fax: (_____)_____

Insulin: ☐ Insulin lispro (Humalog® or Admelog®) ☐ Insulin aspart (Novolog®) ☐ Insulin glulisine (Apidra®)

Insulin Administration: ☐ Syringe/Vial ☐ Insulin Pen ☐ Insulin Pump

I, _____, as the parent of _____, request that he/she be allowed to independently perform the following diabetes care tasks during regular school hours and at school-sponsored activities:

☐ Check glucose within classroom and other designated school areas:
_____

☐ Treat mild to moderate low glucose in classroom and other designated school areas:
_____

Self-administer insulin using: ☐ Subcutaneous injection delivery
☐ Pump delivery ☐ Change own insulin pump infusion site

☐ Self-determine carbohydrate grams
☐ Self-determine insulin bolus
☐ Self-carry all necessary supplies and equipment to perform diabetes tasks

I also request that school personnel perform the following diabetes care tasks during regular school hours and at school-sponsored activities:

☐ Verify low glucose readings
☐ Verify all glucose readings
☐ Verify all insulin doses
☐ Treat severe low glucose with glucagon (according to Cincinnati Children's Hospital medical orders for a student with diabetes)

_____ _____ _____
Parent/Guardian Name (please print) Parent/Guardian Signature Date

(____)_____
Parent/Guardian Phone Number

I support the parent(s) decision to have student self-manage diabetes care at school for the areas checked by the parent above:

_____ _____ _____
Diabetes Provider Name (please print) Diabetes Provider Signature Date

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