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 ☐ Pen ☐ 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 blood glucose with blood glucose meter in classroom and other designated school areas:

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

  _____
- ☐ Self-administer insulin using: ☐ Subcutaneous injection delivery ☐ Pump delivery
- ☐ 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 blood glucose readings on the blood glucose meter
- ☐ Verify all blood glucose readings on the blood glucose meter
- ☐ Verify all insulin doses
- ☐ Treat severe low blood 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

Cincinnati Children's Diabetes Center
3333 Burnet Ave, Cincinnati, OH 45229-3039
Phone: (513) 636-3005 **Fax: (513) 636-9677**
Email: diabetescallcenter@cchmc.org