Health Services Department

Diabetes Self-Carry / Administration of Medication Authorization Form

Student's Name:_____ Date of Birth:_____ Grade:_____

School Name: _____

The following section is to be completed by the parent or legal guardian:

List child's health conditions and allergies:_____

_____

I give permission for my child, named above, to self-administer the following medication/treatment supplies:

Medication/Treatment Supplies	Insulin	Insulin Pen	Insulin Pump	Glucose Tablets	Glucagon	Ketone Strips	Meter/Test Strips	Lancets
Expiration								
Authorization with parent/guardian initials								

Prescribing doctor's name if indicated for prescription:_____

Beginning Date:_____ End Date (last day of school unless otherwise listed):_____

PARENT/GUARDIAN AUTHORIZATION

I take responsibility for this self-carry permission and will not hold Alachua County Public School personnel responsible in the event my child should fail to self-administer according to their doctor's instructions or follow the directions on their Diabetes Medical Management Plan (DMMP). I understand that all medication and treatment supplies must be in the student's name and in the original in-date pharmacy container labeled appropriately by the pharmacy.

If a student who is self-carrying medication and/or treatment supplies is found to be unreliable, abusive of the medication/supplies, or if they share the medication/supplies with other students, the self-carry privilege will be revoked and reported to administration. This could result in disciplinary consequences for the student. **I understand that, for safety reasons, it is important for the school to know what medication(s) my child is taking and if any changes in the prescription occurs the school nurse will be notified.**

Parent/Guardian Name:_____ Relationship:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Signature:_____ Date:_____