



Circleville City Schools

Request for Student to Self-Administer Prescription Insulin Via an Insulin Pump

Student's Name _____ School/Grade/Teacher _____

- The student's Ohio licensed health care prescriber must complete and sign Section I of this form at the beginning of each school year.
Parent or guardian must complete and sign Section II of this form at the beginning of each school year.
This completed form must be on file in the student's health record before student can self-administer insulin via an insulin pump at school.

I. Prescriber's Section

Prescriber's name/title (printed): _____ Phone: _____

This is to certify that the student named above is under my care for treatment of diabetes and has been prescribed an insulin pump to provide his/her insulin. If the student's pump is not functioning properly, the same parameters for calculating the insulin bolus for the pump are to be used to calculate the insulin dose for a back-up syringe or pen as needed.

Please check ONE of the following with regard to a student's independent functioning:

- This student is fully instructed and capable of independently counting carbohydrates, calculating corrections based on the blood glucose, determining insulin boluses and self-administering insulin via his/her insulin pump.
This student will require supervision or assistance with: BG checks, carbohydrate counts, calculating insulin bolus, interventions, corrections, administration of insulin.

Table with 2 columns: Description and Value/Range. Rows include: Insulin prescribed for student's pump, Student's basal rate pump setting at school, Lunch insulin to carbohydrate ratio, Snack insulin to carbohydrate ratio, Correction factor, If blood glucose is less than... before lunch or snack, student is to either (check one), Severe adverse reactions to report to Prescriber, Special storage instructions for extra or back-up insulin, Starting and ending date of this request.

Prescriber's signature/title: _____ Date: _____

II. Parent/Guardian's Section

I hereby authorize the provision of medically prescribed treatment of my child's diabetes in accordance with the above written instructions of my child's licensed health care prescriber. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

I understand I must furnish all the necessary equipment, supplies, and medication for my child's insulin pump. I understand that school staff is not able to determine the carbohydrate counts or portions of my child's lunch and that if he/she requires assistance I will either provide the lunch carbohydrate count to the school each day or will be called to determine or verify the carbohydrate count and insulin dose for my child.

I agree to submit a revised Request for Student to Self-Administer Prescription Insulin Via an Insulin Pump (form 5330 I F2) if anything changes.

I understand that this request entails special circumstances justifying an exception from the usual procedures for administration of medication at school by school personnel.

Parent/Guardian signature: _____ Date: _____

Home address: _____ Daytime phone: _____