Plan For _____ (Student) Dated: _____

DIABETES MEDICAL MANAGEMENT PLAN

I. CONTACT AND PLAN INFORMATION

Student's Name: _____ **Date of Birth:** _____/____/_____
(Month) (Day) (Year)

Health Condition: ☐ Diabetes type 1 ☐ Diabetes type 2 (For t*his Plan "Health Condition" means diabetes)*

Mother/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell_____

Father/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider:_____

Address: _____

Telephone: _____ Emergency Number: _____

Other Emergency Contacts:_____

Relationship: _____

Telephone: Home _____ Work _____ Cell _____

II. PARENT OR GUARDIAN AUTHORIZATION, APPROVAL AND LIABILITY WAIVER

The parents or guardians (hereinafter "Parent") request that Norfolk Public Schools allow the Student to self-manage the health condition and accept and agree to this Medical Management Plan. The Guidelines for Diabetes Medical Management Plan are incorporated into and are a part of this Plan.

Parents understand and agree that if the Student injures school personnel or another student as the result of the misuse of necessary diabetes medical supplies, Parents shall be responsible for any and all costs associated with such injury. Parents acknowledge that (a) the school and its employees and agents are not liable for any injury or death arising from the Student's self-management of the Student's Health Condition and Parents release same from any such claims and (b) Parents shall and do hereby agree to indemnify and hold harmless the school and its employees and agents against any claim arising from the Student's self-management of Student's Health Condition. This release, indemnification and hold harmless agreement shall take effect immediately and shall stay in effect for as long as the Student is provided permission to self-administer medication.

Parent/guardian signature: _____ Date: _____

Parent/guardian signature: _____ Date: _____

III. STUDENT AGREEMENT

I will use the prescription diabetes medication only as prescribed and as permitted by the Plan. I will not share the medication with others and I will not create an unnecessary distraction to others. I have been instructed how to self-administer this medication and understand the side effects of improper use and will follow the Guidelines. I understand that if I do not abide by these terms, I may be disciplined and that this Plan will be re-evaluated. I release the school and its employees of any liability any in way related to this Plan or my use of the medication.

Student signature: _____ Date: _____