BURLINGTON AREA SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT

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AGREEMENT FOR STUDENTS TO INDEPENDENTLY MANAGE THEIR DIABETES

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STUDENT:

- ▢ I agree to dispose of any sharps either by keeping them in my kit and disposing at home or placing them in the sharps container provided at school in the health office
- ▢ I will notify the health office if my blood sugar is below _____ mg/dl or above _____ mg/dl
- ▢ I will not allow any other person to use my diabetic supplies
- ▢ I plan to keep my diabetic supplies:
  ___ with me ___ school health office ___ accessible location: _____
  Location
- ▢ I understand the freedom to management my diabetes independently is a privilege & I agree to abide by this contract

Student Signature: _____ Date: _____

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PARENT / GUARDIAN:

- ▢ I agree that my child can self manage their diabetes and can recognize when they need to seek the help of a staff member
- ▢ It has been recommended to me that back-up supplies be provided to the health office for emergencies
- ▢ I understand that this contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contigencies.

Parent / Guardian Signature: _____ Date: _____

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SCHOOL NURSE:

- ▢ School staff members that have the need to know about the students condition and the need to carry their diabetic supplies have been notified.

School Nurse Signature: _____ Date: _____