NEWPORT NEWS PUBLIC SCHOOLS
Health Services
12465 Warwick Boulevard, Newport News, VA 23606-3041 ▪ phone: 757-591-4646 ▪ fax: 757-595-2017

INSTRUCTIONS TO OBTAIN APPROVAL FOR A STUDENT TO CARRY DIABETES MEDICATIONS AND SUPPLIES

These requests are exceptions to School Board policy JLCD and must be approved.

1. *Parents will submit the following forms with signatures:*
   - ***a.*** ***Request for Approval for Students to Carry Diabetes Medications and Supplies***
   - ***b.*** ***Responsibilities of Student and Parent Requesting Exception to Category BSC and BESO in the Rights and Responsibilities Handbook (Category BSC: Behaviors that Present a Safety Concern and Category BESO: Behaviors that Endanger Self or Others.)***
   - ***c.*** ***Release of Liability***
   - ***d.*** ***Diabetes Medical Management Plan (DMMP)*** *(signed by the medical provider and must indicate the student may self-carry and perform care independently).*

2. *The Registered Nurse (School Nurse) will review the request, determine if there are any circumstances which interfere with approval and contact the prescribing physician if indicated.*

3. *The principal will be advised of the request and determine if there are any circumstances which interfere with the approval of the request.*

4. *The Health Services supervisor will be contacted for questions about approval.*

5. *Parents of students who will self- administer medication should contact the school nurse. The school nurse will discuss safety precautions, as indicated, with the principal, parents, student, teachers and other school personnel regarding students who carry prescribed medication. Students who carry any medication should be trained how to administer it and understand when to seek assistance. The registered nurse may require a demonstration.*

6. *The parents will sign a form assuming full responsibility and releasing the school of liability.*

7. *The school's registered nurse and principal will sign approving the request.*

8. *Approval will be effective only for the school year (including summer school) in which it is signed and must be renewed annually.*

R-05/25

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PARENT REQUEST FOR APPROVAL FOR STUDENT TO CARRY DIABETES MEDICATION AND SUPPLIES

<u>This form is to be completed by the parent</u>. The medical provider must complete the DMMP (Diabetes Medical Management Plan) and indicate that the student may carry diabetes medications and supplies and perform care independently.

Name of Student: _____ Birthdate: _____

Home Address: _____

Name of Parent(s): _____

Additional information: _____

I request that my student carry all diabetes related medications and supplies and perform care independently. I assume responsibility for the use of all medications and supplies at school. I assume full responsibility and release the school from liability. ***A medical provider has completed the necessary parts of this packet and agrees that my child needs to carry diabetes related medications and supplies and understands how and when to use them.*** *I understand this request is for the current school year only.*

Parent Signature: _____ Date: _____

Attached and completed: (All must be reviewed by RN)
___ *Parent Request for Approval (parent signature required)*
___ *Request for Exception to BSC and BESO (parent and student signatures required)*
___ *Release of Liability (parent signature required)*
___ *DMMP signed by Medical Provider indicating student is trained and may self-carry and perform care independently*

Notes:_____
_____
_____

Approved for current school year:

Nurse Signature: _____ Date: _____

Principal Signature: _____ Date: _____

R-05/25

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RESPONSIBILITIES OF STUDENT AND PARENT REQUESTING EXCEPTION TO CATEGORY BSC (Over the counter medications) AND CATEGORY BESO (Prescription medications)
(Request to Carry Prescribed/Over the Counter Medication on One's Person)

I request that my student, _____, carry diabetes medications and supplies and perform care independently**.**

I have read Category BSC and Category BESO which state:

> ***Category BSC****: Drugs: Violating school board non-prescription medication policy and look-alike drug policy. Alcohol: Distributing alcohol to other students. Drugs: Possessing drug paraphernalia*
>
> ***Category BESO****: Drugs: Possessing controlled substances, illegal drugs, inhalants, synthetic hallucinogens, or unauthorized prescription medications. Drugs: Being under the influence of controlled substances, illegal drugs, inhalants, synthetic hallucinogens, or unauthorized prescription medications Drugs: Using controlled substances or using illegal drugs or synthetic hallucinogens or unauthorized prescription medications. Drugs: Distributing controlled substances or prescription medications or illegal drugs or synthetic hallucinogens or alcohol to other students.*

I understand that approval of this request does not release my student from penalty if they misuse this exception. For example: knowingly taking medication improperly, giving medication to another student, or failing to report another student who tries or is suspected of trying to gain access to the medication.

I understand the penalties for misuse of this exception will result in student discipline equal to those violations of Levels 3-5, including a short-term removal from to school to long-term suspension or expulsion.

I have read, reviewed and explained this information to my student. We understand the rules and penalties for misuse of this exception. We acknowledge the responsibilities incurred by the granting of this exception.

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

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RELEASE OF LIABILITY FORM

School: _____ Grade: _____

Student: _____ Birthdate: _____

Address: _____

Parent/Guardian: _____ Phone #: _____

I give permission for my child to self-carry diabetes related medications and supplies and to manage their care independently. I give permission for trained school personnel to provide care in the event my child needs assistance.

I will not hold the school board or any of its employees liable for any negative outcome whether resulting from self-management by my child or from care provided by trained school personnel.

I understand that the school, after consultation with the parent, may impose reasonable limitations or restrictions upon possession and/or self-administration relative to the age and maturity of the student or other relevant consideration.

I understand that the school may withdraw permission to possess and self-administer at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that the student is not safely and effectively self-administering medications and/or managing their own diabetes related care.

Parent Signature: _____ Date: _____