Self-Management Plan Authorization

Student Name: ____ Date of Birth: ______/____/_____
(Month) (Day) (Year)

S[illegible]ol____ Grade ________

PHYSICIAN AUTHORIZATION AND APPROVAL

☐ I have reviewed and approve the attached Action Plan .The student has the ability to safely and responsibly self-manage his/her condition in accordance with this Action Plan.

______________________________________ ______________________________

Physician Name (please print) Phone

______________________________________ ______________________________

Physician Signature Date

PARENT/GUARDIAN AUTHORIZATION AND APPROVAL AND LIABILITY WAIVER FOR SELF MANAGEMENT

The parent/guardian of the Student hereby accept and agree to the attached Action Plan.

The parent/guardian understand and agree that if the student injures school personnel or another student as the result of the misuse of necessary medical supplies, the parent/guardian of the Student shall be responsible for any and all costs associated with such injury. The parent/guardian 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 health condition and the parent/guardian release same from any such claims and (b) the parent/guardian 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 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 manage his/her condition.

______________________________________ ______________________________

Parent/Guardian Signature Date

[illegible]UDENT AGREEMENT FOR SELF MANAGEMENT

I will use the prescription medication only as prescribed and as permitted by the attached Action Plan. I will NOT share it with others. I have been instructed how to self-administer this medication and understand the side effects of improper use and will promptly report self-administration and follow the Guidelines. I understand that if I do not abide by these terms, I may be disciplined and that this Action Plan will be re-evaluated.

______________________________________ ______________________________

Student Signature Date

SCHOOL NURSE APPROVAL FOR SELF-MANAGEMENT

☐ I have reviewed and approve the attached Action Plan. The student has the ability to safely and responsibly self-manage his/her condition in accordance with this Action Plan.

______________________________________ ______________________________

School Nurse Signature Date