This form is developed in partnership and has co-ownership with the South Australian Department for Education and the Department for Health and Wellbeing, Women's and Children's Health Network

Government of South Australia

Insulin medication agreement

for education and care

CONFIDENTIAL

HSP331

This information is confidential and will be available only to relevant staff and emergency medical personnel.

This form must be completed by the child's treating medical practitioner or Diabetes Nurse Educator.

*Insulin medication agreements that are modified, overwritten or illegible will **NOT** be accepted.*

Name of child or young person:			
Date of birth:		Date of next review:	
Allergies:			
Education or care service:			
Education or care service email: (if known)			

MEDICATION INSTRUCTIONS			
MEDICATION NAME			
TIME(S) for insulin administration *(select all those that apply)*	☐ Recess	☐ Lunch	☐ Correction bolus
ADMINISTRATION *(select only one)*	☐ Pump	☐ Pen	☐ Syringe
DOSE AS PER matrix/pump *(select only one)*	☐ Pump	☐ Matrix *(a current matrix must be attached, that includes the child's name and date of development)*	
ADMINISTRATION SUPPORT *(select only one)*	☐ Self-administration with supervision from school staff	☐ Self-administration (no supervision required)	
	☐ Supported by health professional (i.e. Nurse, HSO)	☐ Administered by trained school staff	

AUTHORISATION AND RELEASE (MUST BE COMPLETED BY THE PARENT/LEGAL GUARDIAN)	
☐	The medication documented above is required to be administered during attendance at the education or care service.
☐	I confirm this medication has been administered to my child previously (a first dose cannot be administered in education or care).
☐	My child is well enough for school (no active fever, no diarrhea or vomiting, able to eat and drink as per normal, enough energy to participate throughout the day) and if there is a change in my child's health condition I will be called to collect them.
☐	I approve the release of this information to supervising staff and emergency personnel (if required).
☐	I authorise the medication as instructed above to be administered in the education or care setting.
☐	I certify the above statements are true and correct.
Legal guardian/ or adult student/client _____ _____ First name (please print) Family name (please print)	
Email or signature:	Date:

AGREEMENT: TREATING MEDICAL PRACTITIONER OR DIABETES NURSE EDUCATOR TO COMPLETE		
☐	I agree the medication instructions as written above are appropriate for administration in the education or care setting	
(print name & practice/hospital or stamp)	Date	
	Professional role	
Telephone	Email or signature	

INSULIN MEDICATION AGREEMENT

Health Support Planning