MADISON COUNTY SCHOOLS

Diabetic Action Plan

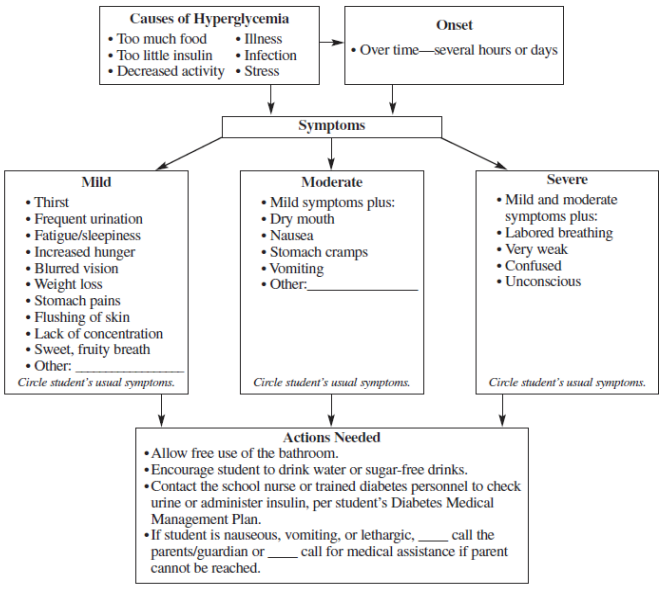
School Year

School:	Grade:	Teacher:
Student's Name:	Date of Birth:	Gender: ☐ Male ☐ Female

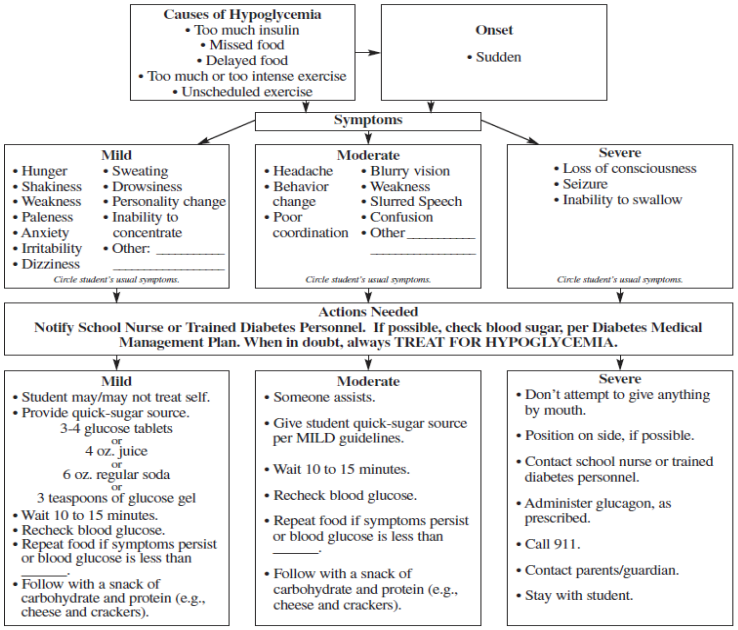
Parent/Guardian Name(s):	Work Phone(s):	Cell Phone(s):
Healthcare Provider Name(s):	Phone:	
School Nurse/Trained Diabetes Personnel	**Contact Phone(s):**	

Please attach this form with Diabetic Plan from Endocrinologist

Hyperglycemia



Hypoglycemia



The parent/guardian releases the school district and its employees and agents from liability for an injury arising from the student's self-administration or staff assistance in administration of diabetic medication while on school property or at a school related event or activity unless in cases of wanton or willful misconduct.

Parent/Guardian Signature

Date: