DUBLIN SCHOOLS

DUBLIN UNIFIED SCHOOL DISTRICT

DIABETES MANAGEMENT AUTHORIZATION & CONSENT FORM

Last Name_____ First Name _____ DOB _____

School _____Grade _____ School Year _____

TO BE COMPLETED BY PARENT/GUARDIAN

Endocrinologist _____ Phone _____

Diabetic Educator_____ Phone _____

Physician _____ Phone _____

Hospital_____ [ ] TAKE TO NEAREST HOSPITAL

EMERGENCY CONTACTS

1.) NAME_____ RELATION_____

HOME#_____ CELL#_____ WORK#_____

2.) NAME_____ RELATION_____

HOME#_____ CELL#_____ WORK#_____

3.) NAME_____RELATION_____

HOME#_____CELL#_____ WORK#_____

A SCHOOL DIABETES MEDICAL MANAGEMENT PLAN MUST BE COMPLETED BY A HEALTHCARE PROVIDER AND ATTACHED TO THIS FORM

DIABETES MANAGEMENT AUTHORIZATION & CONSENT FORM

LAST NAME_____ FIRST NAME_____

TO BE COMPLETED BY PARENT/GUARDIAN

PARENT/GUARDIAN CONSENT FOR DIABETES MANAGEMENT IN SCHOOL

I, the undersigned, request that the following Specialized Physical Health Care Services for the management of diabetes in school to assist my child in accordance to the Education Code 49423.

PLEASE SELECT SPECIALIZED PHYSICAL HEALTH CARE SERVICES

[ ] Blood Glucose testing [ ] Ketone Testing

[ ] Insulin Administration [ ] Glucagon Administration

- I authorize school personnel to assist with the attached School Diabetes Medical Management Plan for my child according to physician instruction. I understand that if appropriate, trained, non-medical personnel may assist with this plan (Ed Code Sec 49423 and 49480).
- This form must be renewed whenever the prescription changes and at the beginning of each school year.
- I will notify the District Nurse/School Personnel immediately and provide new School Diabetes Medical Management Plan for any regimen changes.
- I authorize the District Nurse/School Personnel to communicate with my child's diabetes medical team when necessary.
- I understand that it is my responsibility to bring medication to health office in pharmacy labeled container and that medications must not be expired. All medications and supplies must have student's name clearly marked.
- I understand that it is my responsibility to provide the necessary supplies and equipment, including a copy of operating instructions.
- I request that my child have School Diabetes Medical Management Plan implemented on field trips or in case of disaster**,** according to physician instruction.
- I understand that by signing below I agree to release from liability the district, its officers, employees and agents for any loss, damage, injury or liability of any kind to any person caused or arising from the acts, omissions or negligence of the district, its officers, employees and agents related to the assistance of medication to my child.

PARENT/GUARDIAN SIGNATURE_____**DATE**_____