DUBLIN SCHOOLS

DUBLIN UNIFIED SCHOOL DISTRICT

Last Name_____ First Name_____ DOB_____

School _____ Grade _____ School Year _____

DIABETES MANAGEMENT AUTHORIZATION & CONSENT

TO BE COMPLETED BY PARENT/GUARDIAN

Endocrinologist _____ Phone _____

Diabetic Educator_____ Phone _____

Pediatrician _____ 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#_____

Diabetic Action Plan must be provided by physician and attached to this form.

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DIABETES MANAGEMENT AUTHORIZATION & CONSENT

Student Name _____DOB _____

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.

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-licensed 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 and School personnel immediately and provide new school forms/insulin plan for any regimen changes.
- I authorize the District Nurse and 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**_____