Parent Form

DIABETES MEDICAL MANAGEMENT PLAN

This form must be renewed each school year or with any change in treatment plan

Student's Name: ______________________________ **Date of Birth:** ____________

PARENT CONSENT FOR DIABETES MEDICAL MANAGEMENT PLAN

We (I), the undersigned, the parent(s)/guardian(s) of the above named child, request that this Diabetes Medical Management Plan, and any modification thereto, be implemented while our (my) child is at school or attending a school-related event on or off campus. We (I) understand that the services will be administered to our (my) child in accordance with Education Code section 49423.5. We (I) understand that specialized physical health care services may be performed/monitored by unlicensed designated school personnel under the training and supervision provided by a credentialed school nurse. We (I) agree to:

- Provide the necessary supplies, snacks, medications, and equipment.
- Notify the school nurse if there is a change in pupil health status or attending physician.
- Notify the school nurse immediately and provide new written consent for any changes to this order form.

We (I) understand that we (I) will be provided with a copy of our (my) child's completed Diabetes Medical Management Plan.

We (I) authorize the school nurse to communicate with the physician when necessary.

We (I) also consent to the release of information contained in the Diabetes Medical Management Plan to the Los Alamitos Unified School District staff and other adults who have custodial care of our (my) child and who may need to know this information to maintain our (my) child's health and safety. This consent also extends to other adults who may need to know the information contained in this Diabetes Medical Management Plan to maintain our (my) child's health and safety.

We (I) understand that any written parent/guardian consent for modifications that require physician authorization, as noted above, will not be implemented unless written physician authorization is also submitted to school personnel. All modifications to the Diabetes Medical Management Plan MUST be in written form. The requests for modification received in writing must include the date, the modification, and signatures of both the parent/guardian and the school employee receiving the modification, and a written physician authorization if required. These changes will be attached to his/her Diabetes Medical Management Plan and will be maintained in the student's health record.

______________________	______________________	____________
Student's Parent/Guardian (please print)	Student's Parent/Guardian (signature)	Date
______________________	______________________	____________
Student's Parent/Guardian (please print)	Student's Parent/Guardian (signature)	Date

Reviewed by School Nurse ______________________________ ____________
(signature) Date

Reviewed by Principal ______________________________ ____________
(signature) Date

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Contact Information

Student's Name: ____ Date of Birth ________________

School Name: _____________________________________ Grade: ________ Teacher: ____________________

Parent/Guardian: _____________________________ Relationship to student: ________________________ Telephone: Home ( ) _________________________ Work ( ) _________________________ Cell ( ) _________________________ Address: _____________________________________ _____________________________________	Parent/Guardian: _____________________________ Relationship to student: ________________________ Telephone: Home ( ) _________________________ Work ( ) _________________________ Cell ( ) _________________________ Address: _____________________________________ _____________________________________
Additional Emergency Contact: ________________________________ Relationship to student: ______________ Telephone: Home ( ) _________________________ Work ( ) _________________________ Cell ( ) _________________________	

Student's Primary Health Care Provider

Name: ____

Address: ____

Telephone: ( ) ____-__________ Emergency Number ( ) _____-_________

Student's Pediatric Endocrinologist (3 to 4 visits are recommended each year)

Name: ____

Address: ____

Telephone: ( ) ____-__________ Emergency Number ( ) _____-_________