D155
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Enter with promise. Leave with purpose.

Authorization to Provide Diabetes Care by a Delegated Care Aide, Acknowledgement of Responsibilities, and Release of Healthcare Information

Student Name:_____ **Grade:**_____

School: _____

Delegated Care Aide

As provided by the Illinois *Care of Students with Diabetes Act*, 105 ILCS 145/1 *et seq.,* I hereby authorize Community High School District 155 and its employees, as well as any and all Delegated Care Aides named in my child's Diabetes Care Plan or later designated by the District, to provide diabetes care to my child, consistent with the child's Diabetes Care Plan. I authorize the performance of all duties necessary to assist my child with management of his/her diabetes care at school and school-sponsored activities in accordance with my child's Diabetes Care Plan.

Acknowledgement of Responsibilities & Release of Information

I acknowledge that it is my responsibility to ensure that Community High School District 155 is provided with the most up-to-date and complete information regarding my child's diabetes and treatment, including providing my child's school with a Diabetes Care Plan detailing the health care provider's instructions for managing the child's diabetes care at school, including orders, emergency care, medications, and methods for administering those medications. In addition, I consent to the release of information about my child's diabetes and treatment by my child's health care provider(s) identified below to Community High School District 155. I grant consent to the District to communicate and exchange any and all student records and medical information with the designated health care provider(s). I understand that the purpose of the disclosure is for educational planning and for providing services consistent with my child's Diabetes Care Plan. If I do not grant this consent, the District will not exchange information with my child's health care provider(s), but I will not suffer any other consequences. This consent is valid for one calendar year from the date set forth below and may be revoked at any time in writing. I also understand that I have the right to inspect, copy, and challenge the information to be disclosed pursuant to this consent. I further understand that the information in my child's Diabetes Care Plan will be released to appropriate District employees and officials who have responsibility for or contact with my child and who may need to know this information for my child's health and safety.

Health Care Provider's Name (Print): _____

Phone Number: _____ Fax Number: _____

Email: _____

Pursuant to Section 45 of the *Care of Students with Diabetes Act* (105 ILCS 145/45), I acknowledge and agree that Community High School District 155 and its employees are not liable for civil or other damages as a result of conduct, other than willful or wanton misconduct, related to the care of a student with diabetes. Further, a student who is permitted to self-manage his/her diabetes care pursuant to 105 ILCS 145/30, I indemnify and hold harmless Community High School District 155 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by my child.

Parent/Guardian Signature:_____ Date:_____

Failure of a parent/guardian to execute this form does not affect the civil immunity afforded the District and its employees by Section 45 of the Care of Students with Diabetes Act (105 ILCS 145/45) *for civil or other damages as a result of conduct, other than willful or wanton misconduct, related to the care of a student with diabetes, or any other immunities or defenses to which the District and its employees are otherwise entitled.*