SAN MATEO-FOSTER CITY SCHOOL DISTRICT

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2022 – 2023 School Year

Dear Parent/Guardian,

Keeping students safe and healthy at school continues to be the goal of the San Mateo-Foster City School District's Nursing Department. While students continue to work in Distance Learning for now, we are planning ahead for a time when they will return to in-person instruction at school.

Supporting students diagnosed with Type I diabetes continues to be a priority and we appreciate your help in assisting us in that effort. Thank you for taking a moment to review the attached Diabetes Packet.

During the summer, please have your child's medical team complete and return the attached Diabetes Packet. Also, please be sure your child's most recent orders are included and return your paperwork as soon as possible.

Thank you for your assistance and please let us know if you have any questions.

We look forward to working with you in the new school year.

Sincerely,

The SM-FC Nursing Department

Catherine Le, RN District Nurse
Student Services
1170 Chess Drive
Foster City, California 94404
Tel: 650.312.7295
Fax: 650.655.3394
cle@smfcsd.net

SAN MATEO-FOSTER CITY SCHOOL DISTRICT

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July, 2022

Dear Parent/Guardian,

Keeping students safe and healthy at school continues to be the goal of the San Mateo-Foster City School District's Nursing Department.

Supporting students diagnosed with Type I Diabetes continues to be a priority and we appreciate your help in assisting us in that effort. Thank you for taking a moment to review some important details regarding the management of your child's diabetes while at school or attending the Annex.

- A signed release of medical information form must be submitted **each school year** so that the SMFCSD nursing team can speak directly to your child's medical care team. This ensures an updated and quick response to questions, concerns or changes in orders and also allows the SMFCSD nursing team to discuss your child's diabetes care at school.

- Remember to inform the school immediately of ANY changes in your child's diabetes management. Changes in the diabetes orders or method of insulin delivery (i.e. injection, pen, pump, etc.) will only be accepted from the managing medical team. Please remember to always provide written copies of the change in orders to the school as the most current set of orders on file will be followed.

- Maintaining a two-week supply of diabetic supplies for school management is important – including: method of insulin delivery (injection, pump or pen), insulin, backup insulin, syringes, a SHARPS container, fast acting sugary snacks to manage hypoglycemia (i.e. juice, glucose tabs), glucometer, blood glucose test strips, alcohol wipes, and ketone test strips. Please remember to carefully monitor and replenish your child's supplies regularly to ensure safety while at school.

We appreciate you taking the time to keep us informed so that we can best serve your child. Our goal is to provide consistent care while following current orders in conjunction with the medical team and parents. Please feel free to contact us at any time if you have any questions or concerns.

Sincerely,

The San Mateo-Foster City Nursing Department

___Marilyn Ponce de Leon, RN 650-638-2973 ___Catherine Le, RN 650-312-7295

___Nicole Monozon, RN 650-350-3047 ___Christina Hirsch, LVN 650-312-7297

1170 Chess Drive
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650.312.7700 Tel
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www.smfcsd.net

SAN MATEO – FOSTER CITY SCHOOL DISTRICT
STUDENT AUTHORIZATION FOR RELEASE OF INFORMATION

Student/Parent Information

Name: _____ DOB: _____
Home Address: _____
Information to be Released From: _____
Agency/Person: _____
Address: _____
Phone Number: _____ Fax: _____
Information to be Released to and Used By:
Agency: San Mateo – Foster City School District Attention: _____
Address:
Phone: _____ Fax: _____

Purpose of Requested Information

- ☐ Release of health info at the request of student's parent, guardian or legal representative
- ☐ Provide and plan educational services for student
- ☐ Other: _____

Records: Check the box, initial and/or sign to specify which type of information is to be disclosed.

- ☐ **MEDICAL SUMMARY** _____ (initial)
- ☐ **PHYSICAL EXAM**
- ☐ **PSYCHIATRIC RECORDS**
- ☐ **IMMUNIZATION RECORDS**
- ☐ **LAB/X-RAY/TEST RESULTS**
- ☐ **VERBAL EXCHANGE**
- ☐ **OTHER HEALTH INFORMATION**

Signature	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Specify the records to be disclosed: _____

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (Date)

REVOCATION: This authorization is also subject to written revocation by the parent/guardian at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

A copy of this authorization is as valid as the original. Parent/Guardian has a right to a copy of this authorization.

_____ _____
Signature **Date**

SAN MATEO-FOSTER CITY SCHOOL DISTRICT
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Students Name: _____Birthdate: _____

Teacher: _____Grade: _____

School: _____School Year: _____

PARENT AUTHORIZATION AND RELEASE FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

TO BE COMPLETED BY PHYSICIAN OR OTHER HEALTHCARE PROVIDER LICENSED BY THE STATE OF CALIFORNIA TO PRESCRIBE MEDICATION.

STUDENT NAME (PRINT):_____

DIAGNOSIS FOR WHICH THE MEDICATION IS PRESCRIBED: _____

MEDICATION NAME: _____

Dosage: _____ Time: _____ Route: _____

IF DOSAGE IS AS NEEDED (PRN), THE SYMPTOMS THAT NECESSITATE ADMINISTRATION AND ALLOWABLE FREQUENCY: _____

_____

ESTIMATED TERMINATION DATE: _____

POSSIBLE SIDE EFFECTS: _____

_____

The child named above is under my care. It is necessary for him or her to receive the above-prescribed medication during school hours. The medication may be administered by trained, nonmedical school employees, under the supervision of the school nurse. The school nurse may not be present during administration of the medication.

DATE: _____ PHYSICIAN: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

PHYSICIAN SIGNATURE: _____

PHYSICIAN/CLINIC STAMP: _____

_____

I hereby give permission for school personnel to administer medication to my child during the school day as prescribed by the child's physician.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

IN CASE OF EMERGENCY, PHONE NUMBER I CAN BE REACHED AT: _____

SAN MATEO-FOSTER CITY SCHOOL DISTRICT
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PARENT AUTHORIZATION AND RELEASE FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

California Education Code Section 49423 allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day, provided that appropriate authorization is given.

"Medication" includes prescription medication, over-the-counter medication, nutritional supplements and herbal remedies. Parents are responsible for providing all medication and supplies and equipment necessary to administer the medication. No medications, including over-the-counter medications, will be given without a prescription. The medication prescription must be current and medication must be supplied in the original package or original prescription bottle with pharmacy label attached (ask your pharmacist to divide the medication into two bottles completely labeled: one for home and one for school). The medication must be prescribed to the student to whom it will be administered and all medication containers must include a label with the student's name, physician's name, the name of the medication, and directions for use.

I authorize and hereby request that designated school personnel assist my child in taking this prescribed medication (including prescribed over-the-counter medication, nutritional supplements and herbal remedies) as prescribed by the child's health care provider. I agree to, and do hereby release and hold the District and its employees and contractors harmless from any and all claims, demands, causes of action, liability or loss of any type, because of or arising from acts or omissions with respect to this medication and agree to indemnify each of them with regard to any judgment or claim rendered against them arising out of this medication administration arrangement. I understand that my child may not have or take medication at school unless all requirements are met. I hereby give consent for a school nurse to communicate with my child's health care provider and counsel school personnel as needed with regard to this medication.

_____	M/F	_____
Students Name (Print)	**SEX**	**Date of Birth**

I have read and understand the above authorization and release. I will immediately notify the school if there is any change in medication my child is taking at school. I understand that this authorization is in effect for a maximum of one school year, and the District will require a new authorization the beginning of each school year, or if any changes in prescription occur.

_____	_____
Signature of Parent or Legal Guardian	Date