SAN MATEO-FOSTER CITY
SCHOOL DISTRICT

2024 – 2025 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.

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 or before August 9, 2024.

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

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

Board of Trustees
LaTisa M. Brooks, Alison Proctor, Maggie Trinh, Gene Kim, Maggie Trihn

Superintendent
Diego R. Ochoa

SAN MATEO-FOSTER CITY SCHOOL DISTRICT

2024-2025 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.

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

___Natalie Mainini RN 650-312-7295

___Nicole Monozon, RN 650-350-3047

1170 Chess Drive
Foster City, California 94404
650.312.7700 Tel
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Board of Trustees
LaTisa M. Brooks, Shara Watkins, Alison Proctor, Maggie Trinh, Gene Kim

Superintendent
Diego R. Ochoa

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: ______________________Fa x: ________________
Information to be Released to and Used By:
Agency: San Mateo – Foster City School Distri t 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** ____________________ Signature ________ Date
- ☐ **PSYCHIATRIC RECORDS** ____________________ Signature ________ Date
- ☐ **IMMUNIZATION RECORDS** ____________________ Signature ________ Date
- ☐ **LAB/X-RAY/TEST RESULTS** ____________________ Signature ________ Date
- ☐ **VERBAL EXCHANGE** ____________________ Signature ________ Date
- ☐ **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**

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: ____

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

1/2024