Morris County
Vocational School District

Dear Parent/Guardian,

Your student's health record indicates that he/she has **a history of diabetes** and may or may not require use of medication and/or monitoring of blood sugar while in school.

In order to participate in the athletic program, school-sponsored activities and field trips, the following must be completed and submitted to the School Nurse at the start of EACH school year:

District Policy requires the following information:

1. **All enclosed paperwork** in this packet must be completed by a physician and parent/guardian. Your endocrinologist will provide you with a care plan. If you need one specifically created for MCST, please contact the health office.

2. **If applicable - Diabetes supplies** are to be kept in the health office. This is student specific.This may include but are not limited to: a glucometer, lancets, glucose tablets, glucagon spray, and insulin. **If your child uses a Continuous Glucose Monitoring device, please contact the health office directly for further instructions.**

***All forms must be dated *after July 1st* for the applicable school year.**

No longer has a history of diabetes Provide a note from your child's physician stating he/she no longer is being treated for diabetes.

12th grade students attending CCM/other colleges: These forms are required to be completed and submitted to the health office if your child plans to participate in MCST clubs, athletic teams and school sponsored events and trips

We welcome the opportunity to meet with you and your child to discuss any concerns you may have.

Sincerely,

Ms. Carol Maffei, RN

Ms. Rebecca Reinfeld, RN

School Nurses

Morris County
Vocational School District

Name of Student: Grade:

Section 1: To Be Completed by the Physician: Morris County School of Technology Physician Certification for Self Medication N.J.S.A 18A:40-12.3

I certify that the above name student has the above medical condition which is a potentially life threatening illness. I have discussed the administration of this medication with the above student, and certified that he/she is capable of, and has been instructed, in the proper method of self administration of the medication in an emergency situation as directed above.

Physician's Signature Date

Section 2: To be Completed by the Parent/Guardian: Parent Acknowledgement and Authorization Pursuant to N.J. S.A 18A: 40 - 12.3

A. I give permission for the school nurse to release my child's health concerns as indicated above, to the staff at MCVTS. The school nurse may have indicated this health concern in the genesis program.

Parent/ Guardian Signature Date

B. **Parent Authorization for administration of Glucagon by delegates.** I give consent for the administration of glucagon by the district delegate training by the certified school nurse to administer glucagon in the event that the school nurse is not present at the scene. I understand that the district and its employees shall have no liability as a result of any injury arising from the administration of glucagon to my child and that the parents and guardians shall indemnify and hold harmless the district and its employees.

a. Yes ___ / No: ___

Parent/ Guardian Signature Date

C. **I hereby authorize my child to carry his/her own medication during school, on field trips, and during school sponsored extracurricular activities**. My child has been instructed on self administration of the medication for diabetes in potentially life threatening situations as evidenced by my submission of the above Physician Certification. I also understand that I am responsible for providing the medications and am responsible for replacing it if it is expired or used. By also signing the acknowledgment, I understand that the Board of Education, its employees or agents shall incur no liability as a results of any arising from the self administration or medication of the student; and I hereby indemnify and hold harmless the board and its offices, employees and agents against any claims arising out of the self administration by the student. This permission is effective the current school year only and will be reviewed each subsequent year if the medication needs to be continued.

a. Yes ___ / No: ___

Parent/ Guardian Signature Date