Medical Device Authorization Form **20 - 20** School Year

I am the Parent/Guardian of _____(child)
and I hereby authorize my child to have use of a medical monitoring device such as a continuous glucose monitor (CGM), seizure watch, etc. on his/her person to monitor glucose levels or seizure activity as provided in the Individual Health Plan (IHP) and Emergency Action Plan (EAP). I further grant permission to school personnel of Richland Two to access the medical device of my child. I hereby understand, acknowledge, and agree to the following:

1. I understand that neither South Carolina law nor District policy require the District or its employees to continuously monitor my child's medical device in any manner.

2. I hereby grant to personnel authorized by the District any and all access to my child's medical device.

3. I understand that District school personnel are not able to, and therefore will not, continuously monitor my child's glucose or seizure activity via his/her medical device. Further, any remote access monitoring by school nurses will be done in the health room and will be limited to monitoring for medical device alarms. School nurses will not use medical devices for real-time monitoring of trends in glucose levels, seizure activity, etc.

4. I understand that if the District personnel access my child's CGM or seizure watch, they shall do so via the device provided by the parent, e.g. iPad, mobile phone, Personalized Diabetes Management (PDM), etc.

5. I understand that all medical treatment provided by District school personnel to my child for diabetes-related symptoms or seizure-related symptoms shall be made under the student's Medical orders and/ or the IHP and/or EAP. For diabetes monitoring, a glucometer must be kept at school in the event of a CGM failure, or to verify blood sugar via fingerstick blood sugar.

6. I understand that my child's medical device requires wireless internet service and that the District is not responsible for any lapse in wireless internet service or any wireless "connection" issues of any kind.

7. I understand that I am solely responsible for the maintenance and upkeep of my child's medical device including, but not limited to, ensuring the proper functioning of the CGM, seizure watch, etc., and that any software and/or program updates have been completed according to the manufacturer's instructions. The District is not responsible for any functioning or maintenance issues that may occur with my child's medical device.

8. The District will not rely upon the readings of the medical device if the device is not properly maintained and calibrated. In such a case, the District will refer to Medical orders and/or IHP and EAP for alternative methods of monitoring.

9. I understand that my child's CGM health information or seizure watch information shall be displayed on a screen accessible to personnel authorized by the District. I understand further that as with any device that transmits data remotely, there are privacy concerns. I therefore waive and release the District from any claims under the Family Educational Rights and Privacy Act (FERPA).

_____

Student Last Name, First Name

Medical Device Authorization Form **20___ - 20_____** **School Year**

This form will be updated annually in conjunction with the IHP.

RELEASE/HOLD HARMLESS

By execution of this document, I acknowledge and agree to the above and hold harmless the District, its employees, agents, representatives, and board of trustees, from and against any and all claims, causes of action, damages, losses, and expenses, including attorney's fees, arising out of or resulting from the District's use, or my child's use, of my child's medical device.

Print Name of Student (where applicable)

Signature of Student (where applicable)

Print Name of Parent/Legal Guardian

Signature of Parent/Legal Guardian

Date

Student Last Name, First Name