



Parent/Guardian Consent

Diabetes Medical Management Tasks

School Year: _____ School: _____ Fax: _____

Student Name: _____ Grade: _____ DOB: _____

*This form **must be renewed annually**, and if there are any changes in treatment or medication during the school year. This form must be attached to a completed Diabetes Medical Management Plan (DMMP).*

Parent/Guardian Consent

I request that my child be allowed to take medication at school according to instruction on the attached Diabetes Medical Management Plan (DMMP). I authorize school personnel to assist with this medication for my child as ordered from the above health care provider. I understand trained, non-medical personnel may assist with or administer medication (Ed Code 49423 and 49480). I give consent to communication and exchange of information between PAUSD, the health care provider from the attached DMMP, and the pharmacy listed on the prescription medication above regarding the health care provider's written statement or any other questions about the medication or medication administration.

I understand and agree to the following responsibilities regarding medication administration:

1. The DMMP must be renewed whenever student's prescription changes and at the beginning of each school year. Forms for the next school year must be signed after the current school year has ended.
2. Prescription medication must be in a container labeled by the pharmacist or health care provider and will not be expired.
3. Non-prescription medication must be in the original container with the label intact and will not be expired.
4. An adult must bring the medication to the school health office and pick up any outdated or unused medication.
5. Pill splitting must be done by parent/guardian prior to providing medication to school officials.
6. Parent/Guardian provide all materials or necessary equipment (e.g. measuring spoon) for medication administration.
7. Students may only carry and self-administer an epinephrine delivery systems, inhaled asthma medication, or diabetes management supplies. Exceptions to this rule will be made on a case by case basis in consultation with the district nurse and student's physician. In order to carry and self-administer, there must be written authorization by student, parent, and health care provider.
8. Parent/Guardian will notify the school and provide a new written consent for any changes to the attached DMMP.
9. Any modifications or changes to the attached DMMP may only be made after written notification is received from the health care provider.
10. I understand that 911 will be called in the event emergency medication is given. Emergency medication includes, but is not limited to, epinephrine delivery systems, glucagon, and emergency anti-seizure medications.

Parent/Guardian Signature

Date

Phone

Complete the below sections if the physician indicated the student is independent for all diabetes-related tasks without adult supervision at school and school-sponsored events, except for emergency treatment for hypoglycemia through the administration of glucagon or baqsimi. Parent/Guardian and Student consents to carry and self-administer on Page 2.

Consent To Carry and Self-Administer Diabetes Medical Management Medication and Tasks

Physician Authorization — Physician Authorization may be skipped on this form, if the attached DMMP indicates the student is independent for all diabetes-related tasks without adult supervision at school and all school-sponsored events.

The above student is my patient. I am managing their care, and I am authorized to prescribe medications. It is my professional opinion that for school and school related activities, this student:

_____ [Initial] may carry and preform all diabetes-related tasks without adult supervision, except for emergency treatment for hypoglycemia through the administration of glucagon or baqsimi.

Physician Signature

Date

Phone

Fax

Clinic Stamp

Health Services
25 Churchill Avenue
Palo Alto, CA 94306
Fax 650-833-4226



Parent/Guardian Consent

Diabetes Medical Management Tasks

Parent/Guardian Consent

I give my permission for my child to carry and preform all diabetes-related tasks as directed by the HCP in the DMMP, which I have also signed. I agree that my child has been trained and is competent to carry and self-administer this medication. It is appropriate and acceptable for my child to carry their blood glucose meter, CGM supplies, insulin supplies, and low blood glucose treatment sources with them to take care of themselves. They should be allowed to self-administer diabetes medication and perform all diabetes-related tasks at school and all school-sponsored events as prescribed. I release the Palo Alto Unified School District and school personnel from civil liability if my child suffers an adverse reaction because of self-administering medication or performing diabetes-related tasks. I understand this permission to carry and self-administer medication may be suspended, modified, or revoked by the school district to re-evaluate for any concerns regarding safety, compliance with protocols, or if having the student carry/administer this medication creates an unsafe situation.

Parent/Guardian Signature

Date

Phone

Student Consent

I, _____, will be responsible for carrying, administering, and always keeping safe, my medication and diabetes related supplies.

I agree to preform diabetes related tasks and administer my medication exactly as ordered by my health care provider. I understand that prescription medication must be in a container labeled by the pharmacist or health care provider. I understand that non-prescription medication must be in the original container with label intact. I understand that this medication/equipment is for my personal use only and must be kept in my possession. I will not show or share my medication with other students. I will immediately report to school staff if my medication is missing. I understand that I am responsible for maintaining supplies of my medication and diabetes-related supplies and to notify the school office if there are any problems with my diabetes medication, supplies or equipment. I will inform school staff when I need help or if my symptoms do not get better after taking my insulin or hypoglycemia treatment.

Student Signature

Date

Disclaimer: This release of liability applies solely to the act of self-administration across all school-sponsored programs, extracurriculars, and trips. It does not waive or limit the district's obligation to provide appropriate emergency care, nor does it release the district from liability related to care provided by staff. The district maintains full responsibility for providing a safe environment and explicitly states that care or medical accommodation will not be refused or withheld from the student under any circumstances.

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