Chandler Unified School District #80

Consent and Release to Self-Carry and Self-Administer Diabetes Care

Student Name: _____DOB: _____

School: _____Grade: _____Date: _____

The above-named student may treat his or her own low or high blood sugar, calculate and administer his or her own insulin on school campus, field trips, and school activities off school campus with no supervision of school personnel, and is demonstrated as competent to do so.

Per ARS 15-344.01, if the student is deemed unable to practice proper safety precautions for the handling and disposal of the equipment and medications, the school district reserves the right to withdraw the student's authorization to monitor blood glucose and self-administer diabetes medication.

When diabetes care is done outside of the health office, diabetes care supplies (i.e. syringes, lancets, any item containing blood) must be properly disposed of.

Diabetes Supply Disposal Plan (i.e. store in container and brought home, brought to health office for disposal, placed in parent provided sharps container)

Is your child carrying emergency medication on their person for emergencies? ☐ Yes ☐ No

If no, the following emergency medication will be checked into the health office.
 (please check one)

☐ Glucagon IM ☐ 0.5mg or ☐ 1mg	☐ Baqsimi Intranasal Kit 3mg
☐ Gvoke IM ☐ 0.5mg or ☐ 1mg	☐ Other _____

Licensed Healthcare Provider Name: _____ Phone No. _____

(print)

_____
Licensed Healthcare Provider Signature   Date

I authorize the School District and its employees and agents, on my behalf, to assist in the administration of the medication identified as ordered by my child's physician. **I acknowledge that it may be necessary for the assistance in administration of medication to my child to be performed by an individual other than a nurse, and specifically consent to such practice.**

I understand the law provides that there shall be no liability for civil damages as a result of the assistance in administration of such medication and/or treatment where the person assisting in the administration of such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I understand my child's medication is to be presented to a school representative by an adult. I will assume full responsibility for the supply, appropriate transportation, and maintenance of above medication. If any changes in medication or dosage occur, the school must be notified immediately, and a new form must be completed. I give permission for the exchange of information directly with the healthcare provider regarding my child's medication.

Parent/Guardian Signature: _____Date: _____

Student's Signature: _____Date: _____

District/School Nurse Signature: _____Date: _____