Alachua County Public Schools

Health Services

Diabetic Medication/Treatment Authorization Form

Student's Name:_____ Date of Birth:_____ Grade:_____

School Name:_____ Teacher:_____

Prescribing doctor's name: _____ Allergies: _____

The students' Diabetes Medical Management Plan (DMMP) will be updated annually or whenever the child's medication or management changes. Parents/guardians are responsible for providing the most current copy of their child's DMMP (or doctor's orders) to the school.

Parent/guardian must furnish the school with their child's in-date medication/emergency medication and treatment equipment/supplies. Care cannot be given without adequate medication and/or supplies. If medication or supplies are not available, the parent/guardian will be required to bring the supplies, treat the child at the school themselves or take their child home. If intervention is required for hypoglycemia or hyperglycemia and parent/guardian is not reachable, 911 will be called for treatment. **The following section is to be completed by the parent or legal guardian:**

Medication/Treatment Supplies	Insulin	Insulin Pen	Insulin Pump	Glucose Tablets	Glucagon	Ketone Strips	Meter/Test Strips	Lancets
Expiration								
Authorization with parent/guardian initials								

Dates medication/treatments are to be given:

Start Date:_____ until End of school year unless otherwise indicated here:_____

I hereby grant permission to the school nurse, principal or the trained school-designated staff to assist in the administration of the prescribed medication and/or treatment to my child while in school and away from school while participating in official school activities (F.S.1006.062). I permit Alachua County Public School staff to contact my child's physician and pharmacy in reference to this medication.

I understand the law provides that there shall be no liability as a result of the administration of such medication and/or treatment where the person administering such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances. **I understand it is my responsibility to supply medication refills as described above and treatment supplies when necessary in addition to notifying school personnel of any changes in my child's health condition, medication, doctor orders and/or treatment.**

Parent/Guardian name:_____ Relationship:_____

Home Phone #:_____ Work Phone #:_____ Cell Phone #:_____

Signature:_____ Date:_____

Date	Medication or Supply	Amount in Bottle	Number of Doses/Inventory	Expiration Date	Initial Receiver	Initial Witness

Signature of Receiver/Initial

Signature of Witness/Initial

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