AUTHORIZATION TO CARRY DIABETES EQUIPMENT AND SELF ADMINISTER DIABETES MEDICATION/PROCEDURES

_______________________________ Student Name (print)

_______________________________ Parent / Guardian Name (print)

_______________ Grade

_______________ Homeroom

_______________________________ School Year

Medication(s)/Procedure(s) ____

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In order for your child to carry and administer his/her own diabetes equipment/medication, you must fully complete and return this form **annually** or your child will not be permitted to carry or administer his/her own medication. This is for the safety of your child and others. This form must be filled out **IN ADDITION** to the parent and licensed prescriber's normal authorization form for administration of medication in school.

C. To be completed by the Tennessee licensed healthcare provider:

_______________has been instructed in the proper use of the above-referenced medication(s) /procedure(s). In my professional opinion, this student is responsible and able to utilize the medication(s) and/or carry out these procedure(s) as directed by me without additional assistance. This student should be allowed to carry and use the diabetes equipment/medication(s) listed above.

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(Licensed Prescriber's Signature) (Phone Number) (Date)

D. To be completed by the parent/legal guardian

I request that my child_______________________be permitted to carry and self-administer the above-prescribed medication(s)/procedure(s) while in school, participating in school-sponsored activities, or in transit to or from school or school-sponsored activities. My child has been instructed in and understands the purpose, appropriate method, dosage, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication/equipment. My child acknowledges and agrees that the medication/equipment is for his/her use alone and that he/she will not share it or otherwise allow it to be used by any other student(s) and that to do otherwise is a violation of the Student Code of Conduct which might subject the student to disciplinary action. My child will keep all Sharps secured and dispose of them only in a special Sharps container. My child will immediately notify an employee of Gibson County Special School District (GCSSD) if another student uses his/her medication, equipment, or supplies. My child will immediately notify an employee of his/her school if and when he/she has any questions, concerns or adverse side effects. It is understood that if there is irresponsible behavior or a safety risk, *the* ***privilege*** of carrying his/her medication will be rescinded. I understand and acknowledge that GCSSD assumes no responsibility whatsoever for the maintenance, storage, dosage, or administration of the above student's diabetes medication/equipment. I furthermore agree to indemnify and otherwise hold harmless GCSSD, its employees and volunteers for any and all liability with respect to the student's use of such medication/equipment.

Parent/Guardian Signature: ______________________________ Date: ________________

Student Signature: ______________________________ Date: ________________