DIABETES MEDICATION AUTHORIZATION FORM

IF YOUR SON HAS DIABETES, THIS FORM MUST BE COMPLETED, SIGNED AND RETURNED TO STUDENT SERVICES NO LATER THAN SEPTEMBER 3, 2018.

STUDENT NAME:____ **STUDENT I.D. #**____________________

(PRINT): Last First Middle

IF YOUR SON HAS DIABETES, BUT DOES NOT WANT TO MONITOR HIS GLUCOSE LEVEL BY HIMSELF OR TO SELF-ADMINISTER HIS DIABETES MEDICATION, COMPLETE AND SIGN ONLY THIS SECTION OF THE FORM AND HAVE YOUR SON RETURN IT TO THE STUDENT SERVICES OFFICE.

I, ______________________________, parent/guardian of the above named student, verify that my son has Diabetes, but does **not** want at this time to monitor his glucose level by himself or self-administer his diabetes medication at school, at school-sponsored activities or any time he is present on Saint Xavier High School's property.

X ____ ____________________

Parent/Guardian Signature **Date**

Saint Xavier High School and its employees shall incur no liability as a result of any injury sustained by the student to himself from monitoring his glucose level or self-administration of diabetes medication, or as a result of any injury inflicted on others while monitoring his glucose level or self-administering his diabetes medication.

IF YOUR SON HAS DIABETES AND WANTS TO MONITOR HIS GLUCOSE LEVEL BY HIMSELF AND SELF-ADMINISTER HIS DIABETES MEDICATION AT SCHOOL, YOU AND THE STUDENT'S HEALTH CARE PRACTICIONER MUST COMPLETE AND SIGN ALL SECTIONS BELOW. YOU AND YOUR SON WILL THEN MEET WITH THE SCHOOL NURSE AND ASSISTANT PRINCIPAL FOR STUDENT LIFE TO ASCERTAIN HIS HEALTH CONDITION AND ABILITY TO SELF-ADMINISTER HIS MEDICATIONS.

I, ______________________________, parent/guardian of the above named student, authorize Saint Xavier High School to allow him to carry with him a meter to read his glucose level as well as his diabetes medication.

X ____ ____________________

Parent/Guardian Signature **Date**

I, ______________________________, parent/guardian of the above named student, acknowledge that Saint Xavier High School shall incur no liability as a result of any injury sustained by the student to himself from monitoring his glucose level or self-administration of diabetes medication or as a result of any injury inflicted on others while monitoring his glucose level or self-administering the diabetes medication.

X ____ ____________________

Parent/Guardian Signature **Date**

IF YOUR SON HAS DIABETES AND MUST SELF-ADMINISTER DIABETES MEDICATIONS AT SCHOOL, THE STUDENT'S PHYSICIAN MUST COMPLETE THE FOLLOWING SECTION AND SIGN WHERE INDICATED.

I, ____________________________________, verify that ____________________________________ has Diabetes

Physician/Health Care Provider's Name (please print) **Student's Name (please print)**

and the student has been instructed in self-administration of the diabetes medications listed below:

NAME OF MEDICATION	PRESCRIBED DOSAGE

X ____ ____________________

Physician / Healthcare Provider Signature **Date**