Diabetes Authorization for Self-carry/Administration During School and School Sponsored Activities.

Florida Statutes 385.203, Section 1002.20, House Bill (HB) 747 specifies that students with diabetes will attend their neighborhood school, carry diabetic equipment and supplies, manage their care in the classroom and participate in school-sponsored events free from discrimination. The school must be provided with parental and physician written authorization. This authorization shall identify the diabetic supplies and equipment that the student is authorized to carry and shall describe the activities the child is capable of performing without assistance. The student will keep a copy of this authorization form with their diabetic supplies.

A school district, county health department, and public-private partner, and the employees and volunteers of those entities, shall be indemnified by the parent of a student authorized to carry diabetic supplies or equipment for any and all liability with respect to the student's use of such supplies and equipment pursuant to this paragraph.

Student_____ DOB _____ Grade_____

School _____

Medication/ Supplies: See attached Diabetes Medical Management Plan (DMMP)

Duration (dates) of Administration: From _____ to _____ (Limit: One year).
I request that my child be allowed to carry diabetes medication and supplies. I understand that my child will be responsible for proper usage and storage. I take responsibility for this permission. I also understand that prescription medication must have a current pharmacy label. All non prescription medications/supplies will be accepted in the factory sealed original container and labeled with the name of the student. I will support my child to follow the above agreement and if s/he does not, I will be contacted and we will develop a new plan.

_____ _____ _____
Parent/Guardian Date Daytime Telephone Number

I have demonstrated the correct use of the medication(s) and equipment. I agree to terms of this contract. I will keep my Diabetic supplies in an agreed location. I will not share these items with others. I will notify school authorities when I need to administer the medication.

_____ _____
Student Date

I authorize this student to carry/self-administer the above medication(s) and supplies. He/she has been trained to recognize the signs/symptoms related to diabetes and to correctly use the items prescribed by me and/or my office staff.

_____
Physician's Name/Stamp

_____ _____
Physician's Signature Date

☐ Extra medication in Clinic/Health Room ☐ Original in Clinic/Health Room ☐ Copy to Student