# LEON COUNTY SCHOOLS

## DIABETES MEDICAL MANAGEMENT PLAN & NURSING CARE PLAN

(School Year: 2025- 2026) Plan Effective Date(s): _____

Student's Name: _____ Date of Birth: _____

Date of Diabetes Diagnosis: _____ ☐Type 1 ☐Type 2 School Nurse: _____

School Name: _____ School phone number: _____

Grade: _____ Homeroom: _____ **Independent Management of Diabetes ☐ Yes ☐ No**

### CONTACT INFORMATION

Parent/Guardian #1: _____ Preferred Contact number: _____

Parent/Guardian #2: _____ Preferred Contact number: _____

Other Emergency Contact: _____ Relationship: _____ Phone Number: _____ ALT: _____

Diabetes Healthcare Provider: _____ Phone Number: _____

Diabetes Educator: _____ Phone Number: (850) _____

**MEAL PLAN TYPE:** ☐ Insulin to Carb Ratio ☐ Consistent Carbohydrate: Meal Range: _____grams to _____grams

**Student's self-care nutrition skills:** Snack Range: _____grams to _____grams

☐ Independently counts carbohydrates ☐ May count carbohydrates with supervision

☐ Requires school nurse/UAP diabetes personnel to count carbohydrates

**Meal Plan (meals/snacks child to have):**

| "X" To Select | Meal | Time |
|---|---|---|
| | Breakfast | |
| | Mid-morning snack | |

| "X" To Select | Meal | Time |
|---|---|---|
| | Lunch | |
| | Mid-afternoon snack | |

**Instructions for when food is provided to the class** (e.g., as part of class party or other event): **Notify parent/guardian of party in advance to provide an alternate drink option.**_____

### BLOOD GLUCOSE MONITORING AT SCHOOL:

☐ **Yes** ☐ **No**

☐ School personnel not responsible for testing/monitoring, **but supplies are to be available**

☐ **Blood Glucose test to be performed in school clinic**

☐ In addition to school clinic, may test outside of clinic

Student's self-care blood glucose checking skills:

☐ **Independently checks own blood glucose** ☐ **May check blood glucose with supervision**

☐ **Requires school nurse/UAP diabetes personnel to check blood glucose**

☐ Uses a CGM (continuous glucose monitor) - **See CGM addendum**

- If student is not wearing CGM device, revert to blood glucose testing using glucose meter/finger sticks

☐ Independently treats hypoglycemia outside of clinic

☐ Treats hypoglycemia with supervision

### Time(s) for Glucose monitoring to be performed:

☐ Before breakfast

☐ Midmorning: before snack

☐ Before Lunch

☐ Mid-afternoon

☐ After PE/Activity Time

☒ As needed for signs/symptoms of low/high blood Glucose

☐ 2-hours after a correction bolus

☐ Before Dismissal, give snack if **≤ 100mg/dL**

☐ Before PE/Activity Time **(give snack if < _____mg/dL)**

☐ Other:

**Name:** _____ **Date of Birth:** _____

## INSULIN ADMINISTRATION

**INSULIN ADMINISTRATION DURING SCHOOL:** ☐ School personnel **not** responsible for the administration of insulin

**Insulin Delivery:** ☐ Pen ☐ Pump ☐ In the event of pump holiday/failure, student may inject insulin via insulin pen

**Long-Acting Insulin administration at school:** Lantus/Tresiba/Basaglar/Levemir/Semglee ☐ Yes ☐ No

**If Yes:** Insulin Dose: _____Time: _____

**Rapid acting:** Novolog/Humalog/Admelog/Fiasp ☐ Yes ☐ No

**Time to be given:** ☐ Breakfast (☐Before ☐After); ☐ Lunch (☐Before ☐After); ☐ With Snack ☐AM ☐PM ☐ Other

****If "before" meal is selected and blood glucose is ≤ 100mg/dL or unsure if child will finish all of the meal, may give after meal****

**Insulin Dosing**: ☐ Carbohydrate ratio ☐ Correction Factor ☐ Sliding scale ☐ Fixed insulin Dose ☐ Per pump settings ☐ In-Pen smart insulin pen

**Student's self-care insulin administration skills:**

☐ Independently calculates and gives own dose ☐ May calculate/give own dose with supervision

☐ Requires school nurse or UAP to calculate and student can give own dose with supervision

☐ Requires school nurse or UAP to calculate dose and give dose

**CORRECTION FACTOR:** 1unit of insulin for every ____ points that blood glucose is above or below target of _____mg/dL

***Note: If pre-meal BG is less than target, the amount calculated for total insulin will be less than the amount calculated for food (carb) intake.***

Add correction dose to carbohydrate dose at meals:

☐ Breakfast ☐ Lunch

**Correction Example**

$$\frac{Current\ BG - Target\ BG}{Correction\ Factor} = \_\_\_Units\ of\ Insulin$$

**CARBOHYDRATE (carbs) RATIO:**

☐ Breakfast: 1 unit of insulin per _____ grams of carbs consumed

☐ AM Snack: 1 unit of insulin per _____ grams of carbs consumed

☐ Lunch: 1 unit of insulin per _____ grams of carbs consumed

☐ PM Snack: 1 unit of insulin per _____ grams of carbs consumed

☐ Miscellaneous food/snack/party: 1 unit of insulin per _____ grams of carbs consumed

**Carbohydrate Example**

$$\frac{Grams\ of\ Carb\ to\ be\ eaten}{Insulin\ to\ Carb\ Ratio} = \_\_\_Units\ of\ Insulin$$

**SLIDING SCALE:**

Blood sugar: _____- _____ Insulin Dose: _____

Blood sugar: _____- _____ Insulin Dose: _____

Blood sugar: _____- _____ Insulin Dose: _____

Blood sugar: _____- _____ Insulin Dose: _____

Blood sugar: _____- _____ Insulin Dose: _____

**FIXED INSULIN DOSE:(i.e., student is on predetermined number of units at prescribed time(s))**

| Type of insulin: | Dose: | Time to be given: |
|---|---|---|
| | | |
| | | |
| | | |

## PARENTS/GUARDIANS AUTHORIZATION TO ADJUST INSULIN DOSE

****** Parents requesting to change insulin dosages MUST email request to the Registered Nurse assigned to the school******

☐ Yes ☐ No: Parents/guardians authorization should be obtained before administering a correction dose for hyperglycemia outside of mealtime

☐ Yes ☐ No: Parents/guardians are authorized to increase or decrease correction factor within the following range: **+/-** _____ points that the blood glucose is above/below target blood glucose

☐ Yes ☐ No: Parents/guardians are authorized to increase or decrease carb ratio within the following range: 1 unit per prescribed grams of carb. **+/-** _____ grams of carb

☐ Yes ☐ No: Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: **+/-** _____ units of insulin

Name: _____ Date of Birth: _____

## MANAGEMENT OF HYPERGLYCEMIA (HIGH) BLOOD GLUCOSE (over 300 mg/dl)

**Typical Signs/Symptoms of Hyperglycemia:**

- Increased thirst, urination, appetite
- Tiredness/sleepiness
- Blurred vision
- Warm, dry, or flushed skin
- Other: _____

**Emergency Hyperglycemia Signs/Symptoms:**

- Nausea and/or vomiting
- Rapid, shallow breathing
- Fruity breath
- Severe abdominal pain
- Increased sleepiness/lethargy
- Depressed level of consciousness

**Provide the following treatment:**

- Give extra water and/or sugar-free fluids as tolerated
- Use Insulin correction factor/dose when blood sugar is over **300 and it has been 2 hours since last insulin, *CALL SCHOOL RN FIRST***
- Frequent bathroom privileges
- Check urine ketones if blood glucose over **300** mg/dl
- Return to clinic in 1 hour to recheck blood glucose if ketones trace or lower.
  - ***If blood glucose still over 300 mg/dL, recheck ketones, and follow ketone management protocol***
- CALL parents if ketones are more than trace.

***If ketones are trace or lower it is not necessary for student to go home or to be kept in the clinic.***

**When ketones of small or greater are present:**

- Stay with student and document changes in status.
- Call parent. If unable to reach parent, call School RN for appropriate instruction and/or contact of diabetes care provider.
- Student should be sent home.

## MANAGEMENT OF HYPOGLYCEMIA (LOW) BLOOD GLUCOSE (below 70 mg/dl)

| Mild to Moderate | | Severe |
|---|---|---|
| • Shaky or Jittery<br>• Clammy/Sweaty<br>• Hungry<br>• Pale<br>• Headache<br>• Blurry vision | • Weak/Tired/Lethargic<br>• Inattention/Confused/Disoriented<br>• Dizziness/Staggering<br>• Argumentative/Combative<br>• Change in personality or behavior | • Slurred speech<br>• Inability to eat or drink<br>• Unconscious<br>• Unresponsive<br>• Seizure activity or convulsions (jerking movements) |

Usual symptoms for this student: _____

**Treatment for Mild to Moderate Hypoglycemia**

- Test Blood Glucose (BG)
- ☐ Give **15 grams** fast-acting carbohydrate such as:
  - **3-4 glucose tablets (preferred)**
  - 2-3 rolls of smarties
  - Gummies
  - 4oz. Fruit juice or non-diet soda
  - Concentrated glucose gel or tube gel (for child with trouble swallowing)
  - 8oz. of 1% or fat-free Milk
  - Other: _____
- **IF BG is ≤ 50 mg/dL** = give student with **30 grams** of fast-acting carbs

☐ For students using hybrid closed-loop technology give: _____g of fast-acting carbohydrates. If BG ≤ 50 mg/dL give _____g of fast-acting carbohydrates

- **Retest BG** 15 minutes after treatment
- Repeat treatment until blood glucose over 80 mg/dL
- **Follow treatment with snack of 15g with protein** (i.e., cheese OR peanut butter crackers) **if it will be more than 1 hour until next meal/snack or if going to activity**
- Other: _____

**Treatment for Severe Hypoglycemia**

- Administer glucose gel if student is awake but unable to drink or eat.

**If student is unconscious or having a seizure, presume the student has low blood glucose and:**

- Trained personnel administer: **(Circle ONE)**
  - Glucagon OR GlucaGen:
    - < 9 years old ½ mg
    - ≥ 9 years old 1mg
  - BAQSIMI (3mg) spray in one nostril
  - Administer Gvoke (subcutaneous injection)
    - < 11 years old ½ mg
    - ≥ 12 years old 1mg
  - Zegalogue (subcutaneous injection)
- While treating, have another person call 911.
- Position student on his or her side and maintain this position until recovered from episode.
- Contact student's parent/guardian.
- Stay with student until Emergency Medical Services arrive.
- Notify EMS if student on insulin pump

Name: _____ Date of Birth: _____

**SUPPLIES MUST BE PROVIDED BY PARENT/GUARDIAN AND RESTOCKED THROUGHOUT THE SCHOOL YEAR: (Agreed upon locations noted on emergency card/action plan)**

- ✓ Blood glucose meter, strips, lancets, lancing device
- ✓ Glucose Gel &/or Cake Gel Tube
- ✓ Insulin pen/pen needles/cartridges
- ✓ Other fast-acting carbohydrates (Smarties, gummies, glucose tabs, juice)
- ✓ Ketone testing strips
- ✓ Glucagon Emergency Kit
- ✓ Other carbohydrate & protein snack:( i.e., peanut butter/cheese crackers, granola bars)

**PHYSICAL ACTIVITY, SPORTS, and EMERGENT SITUATIONS (i.e., lockdown, fire, etc.)**

****Quick access to water, fast-acting carbohydrate (glucose tabs, Smarties, gummies, gel), and monitoring equipment is always recommended to be available. ****

**SIGNATURES**

The Diabetes Medical Management Plan (DMMP) is a physician order. By signing this form, you are in agreeance with this treatment plan. If the parent/guardian chooses not to adhere to medical advice, the student is subject to being sent home.

I/we give permission to the school nurse, unlicensed assistive personnel, trained personnel of Leon County Schools, or other qualified health care professional to perform and carry out the diabetes care tasks as outlined in this Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to collaborate with my child's physician/health care provider.

Parent's Signature (Required): _____ Date: _____

Physician's Signature (Required): _____ Date: _____

School Nurse's Signature (Required): _____ Date: _____

**THIS AREA LEFT BLANK**

# LEON COUNTY SCHOOLS

**DIABETES MEDICAL MANAGEMENT PLAN & NURSING CARE PLAN**

(School Year: 2025- 2026) Plan Effective Date(s): _____

**Continuous Glucose Monitor (CGM) Addendum**

Student's Name: _____ Date of Birth: _____

CGM Brand/Model: _____

**The student should be escorted to the nurse/aid if the CGM alarm goes off:**

**☐ Yes ☐ No ☐ Only when sensor is reading < 70 mg/dL or ≥ 300 mg/dL**

**ADDITIONAL INFORMATION FOR STUDENT WITH CGM** (CONTINUOUS GLUCOSE MONITOR)**:**

- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports/activities.
- If the adhesive is peeling, reinforce with approved medical tape.
- If the CGM becomes dislodged, return everything to the parent/guardian. DO NOT throw any part away.
- All CGMs are waterproof, excluding receiver.
- If student is using smart device (phone) as the receiver, the smart device or phone is then considered a medical device

**CGMs contain three parts:**

- **Glucose sensor**: Placed under the skin by the user with an inserter. The electrode that is placed under the skin measures interstitial fluids and the changes in the user's glucose.
- **Transmitter**: Sends the information from the sensor to the device it is connected to.
- **Receiver**: Shows the results obtained by the sensor. This may also be a smart device (phone) or an insulin pump
  - If student is using smart device as the receiver, access to school WiFi is required

☐ ***Guidelines for Dexcom G6 or G7 CGM:***

- Mealtime and/or correction dosing? **YES**
  - Dexcom sensor values may be used in place of finger-stick.
- If at any time the student's symptoms do not match the CGM reading, confirm glucose via finger-stick.
- If CGM reading is "LO" or "HI", check glucose via finger-stick.
- The sensor glucose reading does not have any arrows with it then the CGM is not measuring correctly, and the sensor data cannot be used to dose insulin at that moment and will need to use finger stick until arrows re-appear.
- If student reports that he/she feels low, then the sensor reading may be used to make treatment decisions: follow DMMP orders.
- When treating hypoglycemia follow rule of 15 as described in the DMMP. If at the 15 min. recheck, the sensor value is below 70 mg/dL confirm with a finger-stick prior to treating with another 15 grams of fast-acting glucose.
- "Urgent Low Soon Alert" will alert when the G6 predicts that the student's glucose will be 55mg/dL within 20 minutes. Treat with 15g of fast acting carbohydrate and recheck CGM in 15min.

☐ ***Guidelines for Medtronic Guardian 3/Guardian 4 CGM***

- Mealtime and/or correction dosing? **DEPENDS**
  - Guardian 3 CGM value is not FDA approved to dose insulin for meals
- Do not make therapy decisions based on sensor glucose for Guardian 3. Guardian 4 is approved for insulin dosing.
- Guardian 3 requires calibration every 12 hours. You may be asked to calibrate with a finger-stick glucose prior to lunch
- If at any time the student's symptoms do not match the CGM reading, confirm glucose via finger-stick.

**Name:** _____ **Date of Birth:** _____

☐ ***Guidelines for Freestyle Libre 2 Glucose Sensor:***

- Mealtime and/or correction dosing? **YES**
  - Libre sensor values may be used in place of finger-stick.
- When you see the  symbol, you must check your blood glucose with a blood glucose meter before making any treatment decisions. Sensor readings may not accurately reflect blood glucose levels.
- If at any time the student's symptoms do not match the CGM reading, confirm glucose via finger-stick.
- During the first 12 hours after insertion of a Sensor, Sensor readings will be accompanied by the  symbol. Whenever is displayed, a blood glucose test should be performed to confirm the Sensor reading prior to treatment.
- When treating hypoglycemia follow rule of 15 as described in the DMMP. If at the 15 min. recheck, the sensor value is below 70 mg/dL confirm with a finger-stick prior to treating with another 15 grams of fast-acting glucose.
- The sensor reader needs to be within 20 feet of the student for alerts/alarms to be used.
- Must scan sensor at least every 8 hours.

☐ ***Guidelines for Freestyle Libre 3 CGM:***

- Mealtime and/or correction dosing? **YES**
  - Libre sensor values may be used in place of finger-stick.
- When you see the  symbol, you must check your blood glucose with a blood glucose meter before making any treatment decisions. Sensor readings may not accurately reflect blood glucose levels.
- If at any time the student's symptoms do not match the CGM reading, confirm glucose via finger-stick.
- During the first 12 hours after insertion of a Sensor, Sensor readings will be accompanied by the  symbol. Whenever is displayed, a blood glucose test should be performed to confirm the Sensor reading prior to treatment.
- When treating hypoglycemia follow rule of 15 as described in the DMMP. If at the 15 min. recheck, the sensor value is below 70 mg/dL confirm with a finger-stick prior to treating with another 15 grams of fast-acting glucose.
- The sensor reader needs to be within 33 feet of the student for alerts/alarms to be used.

## SIGNATURES

The Diabetes Medical Management Plan (DMMP) is a physician order. By signing this form, you are in agreeance with this treatment plan. If the parent/guardian chooses not to adhere to medical advice, the student is subject to being sent home.

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Parent's Signature (Required): _____ Date: _____

Physician's Signature (Required): _____ Date: _____

School Nurse's Signature (Required): _____ Date: _____

# LEON COUNTY SCHOOLS

**DIABETES MEDICAL MANAGEMENT PLAN & NURSING CARE PLAN**

(School Year: 2025- 2026) Plan Effective Date(s): _____

**ADDENDUM - FOR STUDENTS WITH INSULIN PUMP**

Student's Name: _____ Date of Birth: _____

Brand/Model of pump: _____

**Physical Activity:**

_____

_____

✓ **If student has discontinued use of insulin pump, parents must notify school RN before returning to school without pump. Parent must provide updated insulin dosing instructions in writing, you may email the instructions to your school's RN.**

| Student's Self-Care Pump Skills | Independent | |
|---|---|---|
| Counts carbohydrates | ☐ Yes | ☐ No |
| Calculates correct amount of insulin for carbohydrates consumed | ☐ Yes | ☐ No |
| Administers correction bolus | ☐ Yes | ☐ No |
| Calculates and sets basal profiles | ☐ Yes | ☐ No |
| Calculates and sets temporary basal rate | ☐ Yes | ☐ No |
| Prepares reservoir, cartridge, pod, and/or tubing | ☐ Yes | ☐ No |
| Inserts infusion set | ☐ Yes | ☐ No |
| Troubleshoots alerts and alarms | ☐ Yes | ☐ No |
| Give injection with pen/syringe if needed **and** pen/syringe available | ☐ Yes | ☐ No |
| Suspend pump | ☐ Yes | ☐ No |
| Changes batteries / Charge Pump | ☐ Yes | ☐ No |
| Disconnects pump | ☐ Yes | ☐ No |
| Reconnects pump to infusion set | ☐ Yes | ☐ No |

**Supplies to be furnished by parent(s)/guardian(s) based upon the *Student's Self-Care Pump Skills*:**

✓ Infusion set/reservoir/cartridge/Pods
✓ Batteries/charger
✓ Rapid acting insulin pen or syringe to administer injection

## SIGNATURES

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Parent's Signature (Required): _____ Date: _____

Physician's Signature (Required): _____ Date: _____

School Nurse's Signature (Required): _____ Date: _____

# LEON COUNTY SCHOOLS
# AUTHORIZATION FOR MEDICATION OR TREATMENT
**(Use one form for each medication. This permission form is valid for the current school year only.)**

I hereby certify that it is necessary for my child, _____(first/last name), _____(date of birth), to be given the medication or treatment listed below during the school day, including when she/he is away from school property on official school business. I hereby authorize the School Board of Leon Count, Florida (LCSB), and Florida Department of Health in Leon County (DOHLC) and their officers, employees, contractors, and agents to assist my child with medication administration and/or to supervise my child's self-administration of medication (s) as directed by his/her prescribing physician(s). I acknowledge and agree that non-health professionals, trained in medication administration, may assist my child with medication administration.

This form must be signed for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc. **Only FDA-approved prescribed and over-the-counter medicines will be accepted.**

Name of medication: _____

Reason for medication (diagnosis): _____

Dosage to be given: _____ Route (mouth, injection, etc.): _____

Time(s) of administration: _____ Allergies: _____

Beginning date: _____ Ending date: _____ Amount of liquid or count of pills: _____

**Emergency telephone numbers:**

Parent/Guardian: _____ H: _____ C: _____

Parent/Guardian: _____ H: _____ C: _____

Doctor's name: _____ Doctor's Phone Number: _____

Prescription and over-the-counter medications/treatments shall come in the original, labeled containers. Changes in medication times or dosage can only be made by written prescription from the physician, which may be faxed/scanned to school health personnel. Over-the-counter drugs/treatments shall **only** be administered for **five calendar days** without a signed licensed prescriber statement. A licensed prescriber must provide signed authorization for a student to self-carry or self-administer medications/treatments allowed by statute 1002.20 and LCSB policy.

Parents are responsible for safe delivery of medication to the school (students may NOT transport medication unless authorized to self-carry emergency medications) and for picking up any leftover medication within ONE WEEK after the ending date. Medication left after this time will be discarded according to LCSB policy.

I hereby consent for the Leon County School District to disclose protected health information, as needed, to provide health services to my child. I understand this health information may be shared with the health care provider listed above, and I hereby authorize the exchange of this information. I also give permission for the information on this form to be utilized by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

I hereby release, indemnify, and hold harmless LCSB, DOHLC, and any of their officers, employees, contractors, and agents from any and all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also hereby agree to indemnify and hold LCSB, DOHLC and their officers, employees, contractors, and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

_____ _____

Date Parent/Guardian Signature

_____ _____

Date RN Signature

# LEON COUNTY SCHOOLS
# AUTHORIZATION FOR MEDICATION OR TREATMENT
**(Use one form for each medication. This permission form is valid for the current school year only.)**

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Reason for medication (diagnosis): _____

Dosage to be given: _____ Route (mouth, injection, etc.): _____

Time(s) of administration: _____ Allergies: _____

Beginning date: _____ Ending date: _____ Amount of liquid or count of pills: _____

**Emergency telephone numbers:**

Parent/Guardian: _____ H: _____ C: _____

Parent/Guardian: _____ H: _____ C: _____

Doctor's name: _____ Doctor's Phone Number: _____

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Parents are responsible for safe delivery of medication to the school (students may NOT transport medication unless authorized to self-carry emergency medications) and for picking up any leftover medication within ONE WEEK after the ending date. Medication left after this time will be discarded according to LCSB policy.

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I hereby release, indemnify, and hold harmless LCSB, DOHLC, and any of their officers, employees, contractors, and agents from any and all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also hereby agree to indemnify and hold LCSB, DOHLC and their officers, employees, contractors, and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

_____ _____
Date Parent/Guardian Signature

_____ _____
Date RN Signature

# Leon County Schools

AUTHORIZATION TO CARRY MEDICATION(S) PERMITIED BY FLORIDA STATUTE 1002.20:
ASTHMA INHALERS, EPINEPHRINE AUTO-INJECTORS, DIABETES SUPPLIES OR PANCREATIC ENZYMES

Date: _____

Student Name: _____ DOB: _____

School: _____ Grade: _____

---

It is medically necessary for this student to carry his/her medication and/or supplies while in school as permitted by Florida Statute 1002.20. This student is capable of self-management and administration of the following medication and/or supplies.

**This authorization is valid for the current school year only (if for specific dates, please specify)**

Medication and/or Supplies: _____

_____

Dosage/instructions: _____

_____

Diagnosis: _____

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Physician Signature | Physician Name | Phone Number | Date |

---

I have read and understand the waiver of liability statements on the Authorization for Medication and feel that my child is capable of self-management and administration of the above medication/supplies.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Parent Signature | Parent Name | Phone Number | Date |

---

*** For staff use only***

The student has demonstrated that he/she is responsible in the use and storage of the above medication.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| FDOH RN Signature | FDOH RN Name | Phone Number | Date |

# Florida Department of Health in Leon County

## CONSENT FOR SHARING OF PROTECTED HEALTH INFORMATION

**School Year**_____

**Student's Name**: _____
**DOB:** _____
**School:** _____

I hereby consent to health information being shared to carry out treatment or clarify medical orders in order to keep my child safe while at school. I understand that Registered Nurses from the Florida Department of Health inLeon County, School Health Division, may be giving and receiving information pertaining to the management of my child's medical condition with the following organizations:

**(Please check *and* initial all that apply)**

___ [X] Leon County School District
___ [ ] Tallahassee Memorial Hospital Diabetes Center
___ [ ] Children's Medical Services
(Name of case manager: _____)
___ [X] Florida Department of Health in Leon County (Health Department)
___ [ ] Tallahassee Pediatric Foundation

___ [ ] Primary Physician_____
(Please fill in Physician name)
___ [ ] Specialist Physician_____
(Please fill in Physician name)

I may request a notice of the complete description of such uses and disclosures prior to signing this consent.

I understand that I have the right to revoke this consent in writing.

_____ _____

Signature Date