MOLALLA RIVER

PARENT AUTHORIZATION FOR DIABETIC CARE

Student: DOB:

School:

As the parent or guardian of the above referenced student, I request my child receive the following health care services(s) related to management of Type 1 Diabetes in the school setting, to include: ☐ assistance with ☐ supervision of:

- ☐ Blood glucose testing and monitoring
- ☐ Carbohydrate counting
- ☐ Response to hyperglycemia, including ketone testing
- ☐ Insulin dosing & administration
- ☐ Treating hypoglycemia

per MD orders and nursing protocol.

I understand that qualified, designated persons will be performing the above-mentioned health care service(s). It is my understanding that in performing this service, the designated persons will be trained and supervised by a registered nurse as authorized by OAR 851-047-0000.

I will notify the school immediately if the health status changes, if there is a change of physicians, changes to physician's orders, and/or change or cancellation of the procedure.

Signature of Parent/Guardian Date