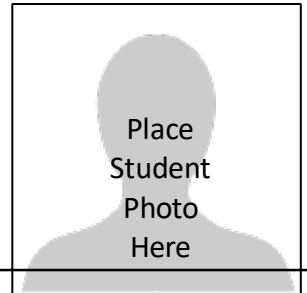


AUTHORIZATION TO CARRY DIABETES SUPPLIES AND SELF-ADMINISTER MEDICATION/TREATMENT

Section 1002.20, Fla. Stat. (2020)

Ina A. Colen Academy
5080 SW 66th Ct. Rd. Ocala, FL 34474
Contact Us: 352-304-6787 info@iacafl.org



Request Beginning (Date): _____ To: _____
Not to exceed one (1) school year Form must be renewed *each* school year

Student: _____ Student #: _____ Date of Birth: _____ Grade: _____
 Parent/Guardian: _____ Contact #: _____
PLEASE PRINT
 Ordering Physician: _____ Physician Phone: _____
PLEASE PRINT

*For your child to carry their own diabetes supplies/equipment and/or medication you must fully complete and return this form **annually**. This is for the safety of your child and others. In addition to this form, the Diabetes Medical Management Plan from your licensed provider must also be submitted to your child's school.*

TO BE COMPLETED BY PARENT/GUARDIAN

I request my child, _____, be permitted to carry and/or self-administer the prescribed medication(s) and/or procedure(s) indicated below while at the After School Care Program.

	<u>Self-Carry</u>		MEDICATION, SUPPLIES, PROCEDURES	<u>Self-Administer</u>	
	Yes	No		Yes	No
			Blood Glucose Meter & Required Supplies for Use		
			Continuous Glucose Monitor Receiver and/or Smartphone		
			Ketone Test Strips		
			Glucagon Emergency Kit (Specify Type):	n/a	
			Insulin (List Medication Name):		
			Syringes, needles, alcohol wipes		

In addition, I agree to the following:

- My child has received instruction and understands the purpose, dosage, frequency, correct technique and use of their medication/treatment.
- My child understands that they are responsible and accountable for carrying, using, and disposing of their medication/supplies properly. All needles/lancets must be disposed in an approved sharps box.
- My child understands that the medication/supplies are for their use only and agrees that they will not share or otherwise allow any other student(s) to use their medication/supplies. Sharing or supplying others with medication is a violation of the Student Code of Conduct and may result in disciplinary action.
- My child will immediately notify an Ina A. Colen Academy staff member if another student uses their medication, equipment, or supplies.
- My child will immediately notify an Ina A. Colen Academy staff member if and when they have any questions, concerns or adverse side effects.
- If my child displays irresponsible behavior or poses a safety risk, the privilege of carrying his/her medication will be rescinded.

I UNDERSTAND AND ACKNOWLEDGE THAT THE INA A. COLEN ACADEMY ASSUMES NO RESPONSIBILITY WHATSOEVER FOR THE MAINTENANCE, STORAGE, DOSAGE, OR ADMINISTRATION OF THE ABOVE CHILD'S DIABETES MEDICATION/EQUIPMENT. I HEREBY INDEMNIFY AND OTHERWISE HOLD HARMLESS THE INA A. COLEN ACADEMY, ITS EMPLOYEES, CONTRACTORS, AND VOLUNTEERS, AND THE MARION COUNTY HEALTH DEPARTMENT, FROM ANY AND ALL LIABILITY WITH RESPECT TO CHILD'S USE OR MISUSE OF SUCH MEDICATION/EQUIPMENT IN THE TREATMENT OF MY CHILD.

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER:

_____ received instruction on the proper use of the medication(s) and/or procedure(s) indicated above. In my professional opinion, this student is responsible and capable of self-carrying and/or self-administering the medication(s) and/or procedure(s) as directed in the student's Diabetes Medical Management Plan, without assistance.

Licensed Prescriber's Signature: _____ Date: _____