____________________ School District
Limited Waiver of Medical Services

Date:___________________________________

Student Name:___________________________

California Education Code Section 49480 requires the parent or legal guardian of any public school student to notify the ________________ School District of any continuing medication regimen. This includes insulin given on a daily basis and in emergency situations. Insulin and syringes will be stored for use in the health office only, with a physician's form describing type, dosage and frequency. It is necessary that the District have a **written protocol** for various blood sugar levels.

The District is willing to offer the services of storage, use and monitoring of blood glucose testing in the health office. However, a request by the parents/guardians to foster independence and responsibility, _______________________________ will test his/her blood sugar level in the classroom during the ____-____ school year. With signed permission by the parent/guardian, student, physician, and teacher, ___________________ will independently monitor and assume all responsibility for glucose monitoring, recording and low glucose treatment. The Staff at the District will be available to assist the student when insulin is required and if emergency treatment in necessary.

The above-named student has been instructed in the proper use of the blood glucose meter, including safety to self and others, and can monitor blood glucose and treat low blood glucose independently outside of the health office. We the parents/guardian feel that our child is responsible for their personal care and we understand that the health office will be unaware of any problems unless our child reports to the health office or to the teacher with this information.

The undersigned hereby acknowledges that he/she knowingly and voluntarily assumes all risks of bodily injury to his/her child, and expressly acknowledges their intention, by executing this instrument, to exempt and relieve the District, its officers, agents, and employees, from any liability for personal injury, bodily injury, property damage or wrongful death that may arise out of or in any way be connected with the testing procedure. I have read the foregoing and have voluntarily signed this agreement. I am aware of the potential risks involved in allowing my child to self-administer this test and I am fully aware of the legal consequences of signing this instrument. I further acknowledge that the District does not provide medical coverage for my child.

Parent/Guardian
Signature____Date_______________

Parent/Guardian Name - Please
____

Attending Physician_____________________________________Date _______________
Family Medical
Insurance Carrier:_____________________________________Policy Number: _________
(e.g., Blue Cross)
In the event of an emergency, please contact:

Name__________________________ Relationship___________________

Work(   )_____________ Cell(   )______________ Home(   )___________