PARK RIDGE-NILES
SCHOOL DISTRICT 64

GLUCOSE SOURCE AUTHORIZATION FORM

Student's Name:_____ Birth Date: _____

Telephone: _____ School: _____

Grade/Room: _____ Teacher: _____

To be completed by the child's physician, physician assistant, or advanced practice registered nurse:

Physician's/Health Care Provider's Printed Name: _____

Office Address: _____

Office Phone: _____

Is it necessary for GLUCOSE SOURCE to be administered during the school day? ___ Yes ___ No

Diagnosis of Student Requiring Glucose Source: _____

Dose: _____Frequency _____

Time When Glucose Source Is To Be Administered: _____

Possible Expected Side Effects: _____

Other Medications Student Is Receiving: _____

Order Date: _____ Discontinuation Date: _____

Physician Signature_____ Date _____

To be completed by the child's parent/guardian:

I hereby authorize the Park Ridge-Niles Community Consolidated School District No. 64 ("School District 64") and its employees and agents to administer or to attempt to administer to my child (or to allow my child to self- administer pursuant to State law, while under the supervision of the employees and agents of the School District), insulin, a lawfully prescribed medication, in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices and I agree to indemnify and hold harmless School District 64 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication. Pursuant to Section 45 of the Care of Students with Diabetes Act, I acknowledge that School District 64 and its employees are not liable for civil or other damages as a result of conduct, other than willful or wanton misconduct, related to the care of a student with diabetes.

Parents/Guardian's Printed Names _____

Parent/Guardian Signature _____ Date _____