

**Authorization for the Administration of Medication
For
STUDENT with DIABETES**

To: _____
School Name and Town

The undersigned, _____ and _____,
(hereinafter "Parent(s)") are the parent(s) of _____
(hereinafter "Student") who is in the ____ Grade Class at _____,
(hereinafter "School"). School Name

Parent(s) of Student hereby authorize(s) and direct(s) the School to administer glucagons medication and blood glucose testing pursuant to the written statement of my/our child's medical provider, a copy of which is attached hereto.

Parent(s) acknowledge(s) that by signing this Authorization, I/we are aware that I/we must also sign a statement acknowledging that School will not incur any liability for such administration, except for willful and wanton conduct with regard to any injury resulting to my/our child. Moreover, Parent(s) acknowledge(s) that they are required to sign an Indemnification and Hold Harmless Agreement with regard to the administration of glucagons medication and blood glucose testing to my/our child.

INDEMNIFICATION and HOLD HARMLESS AGREEMENT

THE Parent(s) hereby agree to indemnify, defend, and hold harmless the School, Parish, and Roman Catholic Diocese of Joliet Trust, its administrators, servants, employees, agents, successors, and assigns (collectively "School Affiliates"), both in their capacities as representatives of the School, the Parish and/or Diocese of Joliet, and as individuals, from and against any loss, notions, responsibilities, obligations, liability, damages, expenses, or claims with regard to the administration of glucagons medication and blood glucose testing to my/our child, _____, with the exception of willful and wanton conduct on the part of any School Affiliates.

Parent/Guardian Signature Date: _____

Parent/Guardian Signature Date: _____

**Written Certification from Licensed Healthcare Provider
for
STUDENT with DIABETES**

1. The undersigned is the healthcare provider of _____.
2. The undersigned is a ____Physician or ____Physician Assistant, who provides medical treatment to the above named child.
3. The patient, _____, is being treated by me for diabetes.
 - a) With regard to treatment for Hypoglycemia (low blood sugar), the following medication has been prescribed:

 - b) The prescribed dosage of such medication is as follows:

 - c) Special circumstances, if any, under which the medication is also to be administered is as follows:

Date: _____

Signature of Healthcare Professional

Printed Name of Healthcare Professional

Name of Office of Healthcare Professional

Office/Company Address

Phone Number of Healthcare Professional