



**HEALTH SERVICES**

Prosper Independent School District

**Parent Acknowledgement and Consent Form for School Diabetes Management**

\*This form is to be renewed each school year.

**Student:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **School Year: 20** \_\_\_\_ **-20** \_\_\_\_

I, the undersigned parent/guardian of Student listed above, request that the Diabetes Management and Treatment Plan ("Plan") completed by my healthcare provider, \_\_\_\_\_, and submitted to the school nurse, be implemented for my Student. Delivery of this Plan to the school nurse constitutes my participation in developing this Plan.

I understand, acknowledge, and agree that it is my responsibility to:

- Provide medical orders for treatment and all necessary diabetic supplies (including glucometer, testing strips, lancing devices and lancets, ketone strips, insulin, syringes, glucose tablets or fast acting sugar source, snack, and any other equipment/food/drinks deemed necessary) and replace these items upon expiration or when supply is low per the school's notification in order for my Student's Plan to be appropriately implemented in the school setting and for off-campus school sponsored activities.
- Communicate directly with the school nurse for all diabetes related care concerns that may affect care at school or school sponsored activities, including communicating atypical blood glucose results at home, as appropriate.
- Notify the school nurse if I change physicians or emergency contact information, or if the Plan is canceled or changes in any way.
- Inform the school nurse of new equipment or other diabetic supplies, special situations, or treatments changes, and provide education of such if needed.
- Collaborate with the school team to implement and evaluate Student's IHP and 504 plan (if applicable).

I understand that medical alert identification (such as a bracelet or necklace) is strongly encouraged to alert others to my Student's diabetes in the event of an emergency.

Regarding the use of **Continuous Glucose Monitors ("CGM") and Automated Insulin Delivery systems ("AID")**, I understand, acknowledge, and agree to the following:

- Neither Texas law nor policy requires the Prosper ISD ("PISD") to access or monitor my Student's CGM or continuously monitor my Student's glucose in any manner.
- Should PISD school personnel monitor my Student's CGM data in the school setting, data will be accessed solely through my Student's personal CGM monitoring device. (An exception can be made for students in early childhood, prekindergarten, or kindergarten if a parent/guardian requests an additional monitoring device in the clinic. Additional form required.) No monitoring program/app will be utilized on any personal staff device.
- CGM-based treatment decisions may be made using a device that is FDA-approved for treatment as indicated on the Student's Plan. I understand that school personnel will check a fingerstick blood glucose to confirm the glucose level in situations where they are not otherwise confident of CGM readings.
- I understand that medications containing acetaminophen (Tylenol) can give false high CGM readings and it is my responsibility to notify the school nurse when my Student has received acetaminophen (Tylenol).
- I understand that my Student's CGM and AID system requires wireless internet service and that PISD is not responsible for any lapse in wireless internet service or any wireless "connection" issues of any kind.
- I understand that I am solely responsible for the maintenance and upkeep of my Student's CGM and/or AID, including, but not limited to, ensuring proper functioning of the CGM and/or AID system, that any and all software and/or program updates have been completed, and that PISD is not responsible for any functional issues that may occur with my Student's CGM and/or AID system and will not use it for treatment if the device(s) is not properly maintained and calibrated.
- If a non-FDA approved device is approved by PISD (through the off-label medication/treatment approval process), and utilized by the Student, the parent (or Student who is approved for independent care) is solely responsible for troubleshooting the system in the event of a system malfunction.
- If my Student is utilizing an AID, I agree to make verbal contact with the Registered Nurse (or Unlicensed Diabetic Care Assistant, if off campus) who is present with the Student PRIOR TO remotely administering insulin or altering insulin delivery to my Student. I authorize the Registered Nurse (or Unlicensed Diabetic Care Assistant) to access my Student's CGM should the Registered Nurse (or Unlicensed Diabetic Care Assistant) determine to have reason to do so.

**Consent for Unlicensed Diabetic Care Assistant (UDCA)**

The health and safety of each student is of paramount importance to every PISD employee. The District is committed to providing a high level of care to meet any special medical needs students exhibit. To help carry out that commitment, PISD ensures that a Registered Nurse is assigned to each campus. House Bill 984 amended the Health and Safety Code to provide more specific requirements for the provision of diabetes management and care services to students in public schools who seek care for the student's diabetes while at school. The school nurse, in conjunction with the

parent, will develop for each student who seeks care for diabetes at school an Individualized Health Plan that will specify the diabetes management and care services the student requires at school. Traditionally, the school nurse has provided any medical care students might require at school. Under HB 984, each school also must train other employees to serve as Unlicensed Diabetes Care Assistants who can provide diabetes management and care services if a nurse is not available when a student needs such services. Such services include the administration of insulin or, in an emergency, glucagon. PISD trains staff at each school to provide such services. HB 984 further specifies that an Unlicensed Diabetes Care Assistant ("UDCA") exercises his or her judgment and discretion in providing diabetes care services and that nothing in the statute limits the immunity from liability afforded to employees under section 22.0511 of the Texas Education Code.

An UDCA may only administer diabetes care and management services if the student's parent/guardian authorizes an UDCA to assist the student.

- I authorize PISD to designate Unlicensed Diabetes Care Assistants who have been trained by PISD Health Services to perform diabetic care tasks as outlined in my Student's Plan for my Student at school in the event that the school nurse is unavailable and/or my Student is unable to perform his/her own care (if authorized to do so). I understand that an UDCA is not liable for civil damages under section 22.0511 of the Texas Education Code.
- I **DO NOT** authorize PISD to designate Unlicensed Diabetes Care Assistants who have been trained by PISD Health Services to perform diabetic care tasks as outlined in my Student's Plan for my Student at school. In the event that my Student requires diabetes care and the school nurse is unavailable or my Student is unable to perform his/her own care (if authorized to do so), the parent/guardian will be contacted to provide care or Emergency Medical Services (EMS) will be activated, and I agree that my insurance carrier or I will assume the responsibility for all costs incurred as a result.

**Consent to Disclose Health Information**

I consent to the release of medical information contained on this form and on my Student's Diabetes Management & Treatment Plan to school officials who have a legitimate educational interest in the information, according to PISD Board Policy and the Family Educational Rights and Privacy Act. I give permission for the release of confidential information regarding my Student's specific health problems to third parties, other than school officials, as required to facilitate medical care and/or treatment of my child. I authorize the nurse and the prescribing physician to confidentially discuss or clarify this Plan and to discuss the Student's response to the prescribed Plan as needed per law (Nurse Practice and Medical Practice Acts of Texas).

**Consent for Diabetes Medications to be Administered at School**

The diabetes medications listed below must be given during school hours. My signature below indicates that I request that PISD staff administer this medication to my Student (or that it be permitted for use in the school setting by my Student with current school year self-care permission also on file). I am giving permission for PISD staff to contact the prescribing provider and pharmacy for additional information regarding this medication, if needed. I agree to pick up any unused, discontinued, or expired medication upon notification by PISD staff. I understand that medications not picked up will be disposed of at the end of the school year or within two weeks after the medication expires or is discontinued, whichever is earlier.

- Insulin:** \_\_\_\_\_ **Amount to be Given:** (see current Diabetes Management & Treatment Plan) **Route:** SQ injection  
**Expiration Date** (of any unopened insulin provided to school): \_\_\_\_\_
- Glucagon:** \_\_\_\_\_ **Amount to be Given:** \_\_\_\_\_ for blood glucose < \_\_\_\_\_ mg/dl & unconscious or seizing  
**Route:**  SQ Injection  IM Injection  Nasal **Expiration Date:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_ **Relationship to Student:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\*OPTIONAL\*\* Parent Permission for Self-Care** (must be accompanied by Physician Permission for Self-Care, annually)

I request that my Student \_\_\_\_\_ be allowed to perform routine diabetes care independently. My Student has been instructed in and understands his/her diabetic self-management. My Student understands that he/ she is responsible and accountable for carrying and using his/her medication and equipment. I hereby give permission for the school to administer the medications as prescribed in the plan above, if indicated (ie. Student requests assistance or becomes unable to perform self-care). I understand that the school nurse, after consultation with the parent/guardian and school administrator, may impose reasonable limitations or restrictions upon my Student's possession and self-administration of diabetes medications relative to his/her age and maturity or other relevant considerations. I understand that PISD may revoke permission to possess supplies and medications to perform the prescribed diabetes management and treatment plan at any point during the school year if it is determined that my Student has abused the privilege of possession and self-care or he/she is not safely and/or effectively performing care or administration of medication. I acknowledge that no provision herein constitutes a waiver of any immunities from suit or from liability that PISD has by operation of law, including the Texas Civil Practice and Remedies Code.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

INTERNAL USE ONLY-----

**Insulin:** RN Initial Review: \_\_\_\_\_  Skyward MAR RN Reviews: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Glucagon:** RN Initial Review: \_\_\_\_\_  Skyward MAR RN Reviews: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_