AFFIDAVIT FOR PARENTAL AUTHORIZATION FOR THE ADMINISTRATION OF DIABETIC INJECTABLES AND / OR DIABETIC PROCEDURES

TO: Hillsborough County School Board
School Health Services
1202 E. Palm Ave.
Tampa, FL 33605
813-273-2378

We/I, the undersigned, _____ ,have enrolled

Our/my child, _____ at _____
(Child's Name) (Name of School)

It may be necessary for my child to have one or more of the following medical procedures performed during school hours.
(Please check off the appropriate procedures)

☐ **1. Finger Sticks for Blood Glucose Monitoring** ☐ **2. Insulin Injections** ☐ **3. Glucagon Injections**

Physician's Orders for these procedures are attached to this document.

We / I specifically request that these procedures be administered by members of the school staff. With the signing of this document, we / I affirm that the individuals listed therein have been trained to perform these procedures to my satisfaction and that the procedures used meets with my approval. We / I thereby release all claims, demands, damages, actions, causes of action or suits at law or in equity, of whatsoever nature against the School Board or any employees for following this request.

We / I also understand that if there is equipment and medication needed to perform this procedure, it will be maintained by us / me; delivered to the school in working order; and that school personnel will assume no responsibility for the proper maintenance or delivery of the equipment or medication necessary for this procedure.

The following staff members have been trained to our / my satisfaction and in accordance with a procedure established by the school under the order of _____
(Physician's Name)

1. Finger Sticks for Blood Glucose Monitoring

Equipment to be supplied by parent	**List Names of Staff Members / Position**
	1.Includes ALL School Health Personnel
_____	_____
_____	_____
_____	_____

2. Insulin Injections

Equipment to be supplied by parent	**List Names of Staff Members / Position**
	1.Includes ALL School Health Personnel
_____	_____
_____	_____
_____	_____

3. Glucagon Injections

Equipment to be supplied by parent	**List Names of Staff Members / Position**
	1.Includes ALL School Health Personnel
_____	_____
_____	_____
_____	_____

SWORN TO AND SUBSCRIBED BEFORE ME ON THIS _____ of _____, _____

Day **Month** **Year**

_____	_____	_____
Signature of Notary	**Date**	**Signature of Parent / Guardian**