Wallington School District

GLUCAGON® AUTHORIZATION

Authorization for Services and Release of Information

I give permission to the school nurse to perform and carryout the diabetes care tasks outlined in the Diabetes Medical Management Plan, Individualized Health Care Plan, and Individualized Emergency Health Care Plan designed for my child_____. I understand that no school employee, including a school nurse or any other officer or agent of a board of education shall be held liable for any good faith act or omission consistent with the provisions of N.J.S.A.18A:40-12.11-12.21.

I authorize the sharing of medical information about my child between my child's physician or advanced practice nurse and other health care providers in the school.

I also consent to the release of information contained in this plan to school personnel who have responsibility for or contact with my child and who may need to know this information to maintain my child's health and safety.

_____	_____	_____
Parent/Guardian Name (Print)	**Parent/Guardian Signature**	**Date**

Permission for Glucagon® Delegate

I give permission for a trained delegate to administer Glucagon® for my child in the event that the school nurse is not physically present at the scene. I understand that no school employee, including a school nurse or any other officer or agent of a board of education shall be held liable for any good faith act or omission consistent with the provisions of N.J.S.A18A:40-12.11-12.21.

_____	_____	_____
Parent/Guardian Name (Print)	**Parent/Guardian Signature**	**Date**