CHICO UNIFIED SCHOOL DISTRICT
1163 E. SEVENTH ST., CHICO, CA 95928

School: _____ **Phone:** _____ **Fax:** _____

PHYSICIANS'S ORDERS (continued)

PLEASE SEE ATTACHED FOR STANDARD PROCEDURE AND COMMENT SECTION

Parent Consent for Care of Diabetes at School

PUPIL:	**DOB:**	**SCHOOL:**	**GRADE:**

We (I), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the above specialized physical health care services for Care of Diabetes in school be administered to our (my) child in accordance with Education Code Section 49423.5.

I will:

1. Provide the necessary supplies and equipment.
2. Notify the school nurse if there is a change in pupil health status or attending physician.
3. Notify the school nurse immediately and provide new consent for any changes in doctor's orders.

I authorize the school nurse to communicate with the physician when necessary.
I understand that I will be provided a copy of my child's completed Individual School Healthcare Plan (ISHP).

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Authorized Physician for Care of Diabetes at School

My signature below provides authorization for the above written orders. This authorization is for a maximum of one year.

☐ I request that the School Nurse provide me with a copy of the completed Individual School Healthcare Plan (ISHP).

☐ I have instructed _____ in the proper way to use his/her **medications**.
(child's name)

It is my professional opinion that this student be allowed to carry and administer such **medications** by himself/herself. Physician's Initial _____

Physician Name _____ Physician Signature _____ Date _____
(Print)

Address _____ City _____ Zip _____

Phone _____ Fax _____

For School District Personnel

_____ _____
Reviewed by School Nurse (Signature) Date

_____ _____
Reviewed by Principal (Signature) Date