COMMUNITY CONSOLIDATED SCHOOL DISTRICT 64 Park Ridge-Niles

164 S. Prospect Avenue Park Ridge, IL 60068-4079 (847) 318-4300 FAX: (847) 318-4351

Authorization to Provide Diabetes Care, Release of Health Care Information, and Acknowledgement of Responsibilities

As provided by the Care of Students with Diabetes Act, I hereby authorize the Park Ridge-Niles Community Consolidated School District No. 64 and its employees, as well as any and all agents as designated in the Individualized Healthcare/Diabetes Care Plan or later designated by the District, to provide diabetes care to my child, _____, consistent with this Care Plan. I authorize the performance of all duties necessary to assist my child with management of his/her diabetes during school.

I acknowledge that it is my responsibility to ensure that the School is provided with the most up-to-date and complete information regarding my child's diabetes and treatment. Therefore, I consent to the release of information about my child's diabetes and treatment by my child's health care provider(s), _____, to representatives of School District 64. I further authorize District representatives to communicate directly with the health care provider(s).

I also understand that the information in the Individualized Healthcare/Diabetes Care Plan will be released to appropriate school employees and officials 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.

Pursuant to Section 45 of the Care of Students with Diabetes Act, I acknowledge that the District and District employees are not liable for civil or other damages as a result of conduct, other than willful or wanton misconduct, related to the care of a student with diabetes.

Parent's Signature:_____ Date:_____