



**DIABETES MEDICATION AND RELEASE FORM FOR SCHOOL AND ATHLETICS  
FOR PROVIDER USE ONLY**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

**\*Able to fully participate in Physical Education/Sports without restriction**  Yes  No

**\*This student requires Glucagon or other emergent medication for school and sports:**

**Yes**

Name of Medication: \_\_\_\_\_

Route, Dose, Time & Frequency: \_\_\_\_\_

**No**

**\*A Nurse is required for field trips**  Yes  No

**Notes:**

Provider Name _____	Provider Role: <input type="checkbox"/> MD/DO <input type="checkbox"/> PA <input type="checkbox"/> NP
Signature _____	Date _____
Stamp:	

**Parent/Guardian Permission**

- I give permission to have the School Nurse/designated school personnel administer the prescribed medication as above during regular school hours.
- I have provided the Diabetic management plan and/or orders completed by a provider to the health office.

The medication is to be administered as ordered during the current school year \_\_\_\_/\_\_\_\_. Any changes to the medication order from the physician will be given, in writing, to the school nurse.

I hereby give permission to the school nurse or designated school personnel for appropriate communication with the ordering physician.

I hereby release the school nurse or designated school personnel and the Board of Education of any liability relative to the administration and/or reaction of the medication on the above named student.

**I agree for all afterschool activities, athletic practices and games:**

- To monitor and provide all diabetic supplies needed.**
- To administer the emergent medication if needed.**

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

■ The mission of the Wappingers Central School District is to empower all of our students with the competencies and confidence to challenge themselves, to pursue their passions, and to realize their potential while growing as responsible members of their community.