GASTON COUNTY SCHOOLS
PARENTAL REQUEST
FOR
INDIVIDUAL DIABETES CARE PLAN

_____
School

Student: _____Grade: _____ Birthdate: _____

Parent/Guardian: _____

Address: _____

Telephone: (H) _____ (W) _____

I hereby request that an Individual Diabetes Care Plan be developed and implemented for my child. I authorize the institution listed above to communicate with the health care provider listed below in order to share and receive health care information. I understand that I must provide a Diabetes Care Plan reviewed by a health care provider and appropriately trained staff will need to be in place prior to my child receiving medical services, other than self care, parent care, and Emergency Medical Services (911) at school. This plan will require annual review and updates, as medical care needs change.

_____ _____
Signature of parent/guardian *Date*

HEALTH CARE PROVIDER INFORMATION

Current physician or health care provider: _____

Address: _____

Telephone: _____ FAX: _____

Reviewed 1/14