Chicago Public Schools

Office of Student Health and Wellness
42 West Street, Garden Level • Chicago, Illinois 60602
Telephone: 773-553-3560 • Fax: 773-553-1883

# Diabetes Delegated Care Aide Authorization Form

| | | |
|---|---|---|
| Student Name | Student ID # | Student Date of Birth |
| School Name | Student Grade | |
| Parent/Guardian Name | Home Address | |
| Parent/Guardian Phone # | Emergency Contact Phone # | Student Date of Birth |
| DCA Name | DCA Title | DCA CPS Employee ID # |

Delegated Care Aides (DCAs) must be full-time employees who volunteer to assist the students with diabetes management and emergency care. According to Illinois law, the DCA is "a school employee who has agreed to receive training in diabetes care and to assist students in implementing their diabetes care plan and has entered into an agreement with a parent or guardian and the school district" (IL General Assembly, 2010).

- ☐ YES – I authorize the above Delegated Care Aide to provide diabetes management and care services to my child at school as outlined in his/her Diabetes Care Plan. I understand that the DCA is immune from civil liability under Section 45 of Illinois Public Act 096-1485.
- ☐ NO – I do not authorize a Delegated Care Aide to provide diabetes management and care services to my child at school. I understand that 911 will be called in the event of an emergency.
- ☐ N/A – My child can manage his/her diabetes independently and will not seek assistance while at school. I understand that 911 will be called in the event of an emergency. This information will be shared with school personnel as needed.

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|---|---|
| Parent/Guardian Signature<br>(Student Signature if 18÷ years old with own educational rights) | Date |
| Principal/Administrator Signature | Date |
| Delegated Care Aide Signature | Date |

THE CHICAGO HIGH SCHOOL FOR THE ARTS

Parents: Only have your doctor complete this form IF you are requesting or have proof of the vaccinations below as waived/exempt.

**CPS Chicago Public Schools**

125 S. Clark
Chicago, Illinois 60603

## PHYSICAL EXAMINATION and/or IMMUNIZATION WAIVER FORM

State law mandates physical examination and specific immunizations. If you as a parent or legal guardian have religious objections or your child's medical doctor has a medical reason indicated against immunization, we must have a completed statement on file.

**Please note that if there is an outbreak of disease for which your child is not immunized, your child may be excluded from school for an indefinite period of time until acceptable proof of immunity is received by the school or the period of communicability for the disease has expired.**

I, _____ (Name), parent or legal guardian (circle one)

of _____ (Child's Name), born on _____ (Date of Birth) object to the

following Immunizations:

| | | | |
|---|---|---|---|
| _____DTaP | _____DPT | _____DT | _____Polio |
| _____MMR | _____Measles | _____Mumps | _____Rubella |
| _____Hepatitis B | _____HIB | _____Varicella (Chicken Pox) | |

☐ Religious Reason: State specific religious belief that forbids immunizations below

☐ Medical Reason: **Physician's Statement must be attached**
State specific medical condition that forbids immunization.

Use additional sheets as needed. Return all pertinent information to your child's school nurse.

_____ (Signature of Parent or Guardian) _____ (Date)

_____ (Address) _____ (Telephone)

- Copy to child's health folder
- Copy to Cluster Office, Nurse Coordinator