JURUPA COMMUNITY SERVICES DISTRICT
PARKS DEPARTMENT

POLICY FOR ADMINISTERING EMERGENCY TREATMENT TO CHILDREN WITH SEVERE ALLERGIES

Children with severe allergies, such as allergies to bee stings, peanut products, etc., may be at risk of a serious allergic reaction while participating in Jurupa Community Services District (JCSD) Parks Department programs and activities due to contact with or ingestion of the allergen. Contact with these allergens may result in anaphylaxis, a severe allergic reaction with symptoms that may include, swelling of the face and lips, hives, vomiting, diarrhea, shortness of breath, and difficulty breathing. Ultimately, anaphylaxis may cause a drop in blood pressure, unconsciousness, and death. The JCSD is concerned for the health and safety of all children participating in its programs and activities. Accordingly, when an enrolling/enrolled child has a severe, life-threatening allergy, the following is required:

PARENT(S)/GUARDIAN(S) MUST COMPLETE AND/OR PROVIDE THE FOLLOWING:

1. A signed copy of the Jurupa Community Services District Parks Department's "Authorization for Emergency Care for Children with Severe Allergies" (Authorization Form). This form must be filled out completely by the child's physician and Parent(s)/Guardian(s), and must be updated every six months, or more frequently, as needed. The Authorization Form is designed to provide District staff and volunteers with the information necessary to ensure proper preventative measures and an effective response to a serious allergic reaction. In addition, the Parent(s)/Guardian(s) shall provide a copy of any other physician's orders and procedural guidelines relating to the prevention and treatment of the child's allergy.
2. A signed copy of the Jurupa Community Services District Parks Department's "Release and Waiver of Liability for Administering Emergency Treatment to Children with Severe Allergies" (Waiver). The Waiver releases the District, its employees, and volunteers from liability for administering treatment to children with severe allergies (including the administration of epinephrine) and taking any other necessary actions set forth in the Authorization Form, provided that the District, its employees and volunteers exercise reasonable care in taking such actions. The Waiver further releases the District from liability for any failure to identify symptoms of an allergic reaction in their child. The Waiver further requires the Parent(s)/Guardian(s) to acknowledge that

any treatment administered will not be provided by medical professionals, and that District employees and volunteers have not received any formal medical training for administering medication or identifying the symptoms of an allergic reaction. The Waiver will also acknowledge that the District cannot provide constant monitoring of the child for the purposes of identifying symptoms of an allergic reaction.

3. All equipment and medications needed by the District, its employees, and volunteers to comply with the instructions set forth in the Authorization Form (including, but not limited to, a device such as the EpiPen. Jr.) will be supplied by the Parent(s)/Guardian(s). The Parent(s)/Guardian(s) is/are responsible for ensuring that all medication is properly labeled by a pharmacist and replaced prior to the expiration date and all equipment is in proper working order.

PROCEDURES FOR EMERGENCY TREATMENT:

If a child enrolled in a JCSD Parks Department class or program has severe allergies, the following steps shall be implemented:

1. Prior to the child's first day of attendance, the Parent(s)/Guardian(s), or their designee(s), is responsible for training selected members of the District staff and/or volunteers on the nature of the child's allergy(ies), including: (i) the events/substances that may trigger allergic reaction (e.g. bee sting, consumption of peanuts or products containing peanuts, etc.); (ii) with respect to food allergies, limitations on the child's food consumption; (iii) symptoms of an allergic reaction; and (iv) when and how to administer treatment for an allergic reaction, including, where appropriate, the procedure for administering epinephrine through an EpiPen, Jr. or similar device.
2. Whenever possible, at least two (2) members of the District staff and/or volunteers will attend the training provided by the Parent(s)/Guardian(s)/Designee(s). Upon completion of the training, the District staff and/or volunteers shall complete and sign the Allergy Emergency Treatment Training Acknowledgement.
3. Training shall be repeated, as needed, which may be every six months or when fifty percent (50%) of the District staff and/or volunteers has turned over, whichever occurs first.
4. The District will make all reasonable efforts to have at least (1) trained District staff member and/or volunteer present at all times the child is present at the class or program, however, it is not possible for the District to guarantee that a trained staff member or volunteer will be present at all times.
5. Medication kept at a JCSD site shall be stored in a secure area, accessible only by trained staff or other designated District employees or volunteers.

During field trips, a trained member of the staff, or other designated employee or volunteers shall be designated to carry any required medication.

6. Warning signs alerting staff of the child's particular allergy shall be posted in the child's classroom or other location of the activity, where possible, and on attendance sheets.

STEPS FOR TREATING AN ALLERGIC REACTION:

All allergic reactions should be treated in accordance with the instructions provided by the child's physician in the Authorization Form. In the event of any conflict between this policy document and the instructions set forth in the Authorization Form, the instructions in the Authorization Form must be followed. If the child is exposed to or ingests the allergen, or shows one or more of the following signs and symptoms of an allergic reaction, including swelling of the lips and face, hives, vomiting, diarrhea, shortness of breath, and difficulty breathing, the District will make all reasonable efforts to follow these steps:

1. A designated staff member or volunteer calls the area's emergency personnel number (e.g. 911), unless stated otherwise in the Authorization Form, and the Parent(s)/Guardian(s) immediately.
2. A trained staff member administers medication (such as Benadryl Elixir or the EpiPen, Jr.) as instructed in the Authorization Form. In emergency situations when a trained District staff member and/or volunteer is not present, a designated staff member or volunteer may administer medication as instructed on the Authorization Form. Unless otherwise indicated on the Authorization Form, these medications should be administered immediately. If a child is exposed to (e.g. bee stings) or ingests (e.g. peanuts) a known allergen, do not wait to administer medication until the child shows the signs of an allergic reaction, unless the Authorization Form states otherwise. If a child exhibits symptoms of an allergic reaction, do not wait to see whether his or her symptoms worsen. **Note: The emergency personnel number (e.g. 911) must be called in addition to giving medication such as the EpiPen, Jr. because the medication only works for approximately fifteen (15) minutes.**
3. Under no circumstances may any JCSD staff member or volunteer administer any medication, including the EpiPen, Jr., until: (i) the child has been identified as subject to anaphylactic reaction; (ii) all the required medical information and Authorization, Waiver and Release forms have been provided by the Parent(s)/Guardian(s); and (iii) the initial training from the Parent(s)/Guardian(s) to District staff and/or volunteers has been completed.

4. If epinephrine is prescribed, only pre-measured doses of epinephrine (such as contained in the EpiPen, Jr.) may be given by District staff and/or volunteers.

JURUPA COMMUNITY SERVICES DISTRICT

PARKS DEPARTMENT

AUTHORIZATION FOR EMERGENCY CARE

OF CHILDREN WITH SEVERE ALLERGIES

Dear Doctor: ___________________________________ Date: ________________

Your patient, ____ is enrolled/enrolling in one of our District programs and we have been requested to provide certain emergency care for the prevention of anaphylaxis in the event the child comes into contact with a certain allergen(s), as described below. Please complete Part I of this instruction record. This record will remain in the child's file at the Jurupa Community Services District so we may assist with the allergy care and needs of our enrollee and your patient. If you need to provide further instructions or clarifications, please do so on a separate sheet of paper, which will become part of this record and will be kept with this form in the child's file.

PART I (to be completed by physician)

Child's Name: ________________________________ Child's Birth Date: ____________

Allergens:

Please provide a complete list of all events and/or substances that may trigger a severe allergic reaction (i.e., anaphylactic shock) in the child.

_____ Bee Sting

_____ Other Insect Bite(s) (Please Identify): ______________________________

_____ Animal Fur (Please Identify): ____________________________________

_____ Food Allergy (Identify all foods that must be avoided): ________________

____

_____ Other (specify): ____

Symptoms

Please provide a complete list of all symptoms that indicate that the child has come into contact with an allergen and that he or she requires emergency treatment.

_____ Shortness of Breath or Difficulty in Breathing

_____ Swelling of the Face or Lips

_____ Hives

_____ Vomiting

_____ Diarrhea

_____ Other (explain): ____

_____ Do NOT administer medication in the absence of known exposure to allergen (explain): ____

Procedures

Please indicate all steps necessary and the order in which they should be taken.

_____ Give Benadryl Elixir, ___ ml orally.

_____ Administer EpiPen, Jr. or _____________________________

_____ Call the area's emergency medical personnel (e.g. 911)

_____ Call Parent(s)/Guardian(s), and the child's physician.

_____ Other (explain): ____

Recreational Activities

1. The child may participate in indoor recreational activities. [ ] Yes [ ] No
2. The child may participate in outdoor recreational activities. [ ] Yes [ ] No
3. Activity restrictions: [ ] None [ ] Some Restrictions (explain): ____

Child's Physician

Name: ____

Address: ____

Telephone No.: ____

Emergency Contact No.: ____

Signature: _________________________________ Date: _________________

PART II (to be completed by Parent(s)/Guardian(s))

Parent(s)/Guardian(s)

Name: ____

Address: ____

Telephone No.: ____

Emergency Contact No.: ____

Name: ____

Address: ____

Telephone No.: ____

Emergency Contact No.: ____

By signing this form, I/We authorize the Jurupa Community Services District staff and/or volunteers to follow the above instructions from my/our child's physician in the Authorization Form. I/We agree to update this form every six (6) months, or sooner if my/our child's needs change.

Signature: ____

Parent/Guardian

Date: ____

Signature: ____

Parent/Guardian

Date: ____

RELEASE AND WAIVER OF LIABILITY FOR ADMINISTERING EMERGENCY TREATMENT TO CHILDREN WITH SEVERE ALLERGIES

This is a RELEASE AND WAIVER OF LIABILITY FOR ADMINISTERING EMERGENCY TREATMENT TO CHILDREN WITH SEVERE ALLERGIES (herein, referred to as the "Release") made this ____ day of ______________, 20_____, by and between the Jurupa Community Services District (JCSD) and ______________________________ [Parent(s)/Guardian(s)] residing at ______________________________________ (address), who are the Parent(s)/Guardian(s) of ____________________________ (child's name and date of birth);

WHEREAS, the JCSD Parks Department provides youth programs at numerous facilities and the Parent(s)/Guardian(s) has enrolled ______________________ (child's name) in a District program;

WHEREAS, the JCSD Parks Department has been requested by the Parent(s)/Guardian(s) to administer emergency treatment (including, the administration of epinephrine) to the child during certain emergency situations when the child has come into contact with an allergen and is in danger of anaphylaxis, as prescribed by the child's physician in writing on the child's "Authorization For Emergency Care of Children with Severe Allergies," all in accordance with and subject to the District's policy for administering emergency treatment to children with severe allergies.

NOW, THEREFORE, in consideration of the agreements and covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

1. Parent(s)/Guardian(s) hereby acknowledges that the treatment administered will not be provided by medical professionals, and that District employees and volunteers have not received any formal medical training for administering medication or any other medical treatment to children suffering from severe allergies and/or anaphylaxis. Parent(s)/Guardian(s) further acknowledges that the only training District employees and volunteers may receive for administering medication or other medical treatment to his/her child is the training provided by Parent(s)/Guardian(s).
2. Parent(s)/Guardian(s) hereby acknowledges that District employees and volunteers have not received any formal medical training for identifying the symptoms of an allergic reaction or anaphylaxis.

3. Parent(s)/Guardian(s) hereby acknowledges that while the District will make all reasonable efforts to have at least one of the employees or volunteers trained by the Parent(s)/Guardian(s) to administer medication or other medical treatment to the child, available at all time, the District cannot guarantee that the staff members or volunteers will be present at all times.
4. Parent(s)/Guardian(s) hereby acknowledges that in emergency situations where District staff and/or volunteers which have been trained by Parent(s)/Guardian(s) to administer medication to the child in the event of an allergic reaction are not present and the child has an allergic reaction, medication or other medical treatment may be administered by other District employees or volunteers.
5. Parent(s)/Guardian(s) hereby releases and forever discharges the JCSD and its employees, volunteers or agents from any and all liability arising in law or equity as a result of the JCSD's employees, volunteers or agents administering epinephrine and/or any other medication provided by the Parent(s)/Guardian(s) or providing any other medical treatment or emergency care, as prescribed by the child's physician, as set forth in the "Authorization for Emergency Care of Children with Severe Allergies," provided that the JCSD has used reasonable care in administering epinephrine and/or any other medication or other medical treatment or emergency care in accordance with the Authorization.
6. Parent(s)/Guardian(s) hereby releases and forever discharges the JCSD and its employees, volunteers or agents from any and all liability arising in law or equity as a result of the JCSD employees or agents failing to identify or misidentifying symptoms of an allergic reaction described by the child's physician in the "Authorization for Emergency Care of Children with Severe Allergies," provided that the JCSD has used reasonable care.
7. This Release supersedes and replaces all prior negotiations and all agreements proposed or otherwise, whether written or oral, concerning all subject matters covered herein. This instrument, along with the Authorization (including, any additional physicians instructions or clarifications), which is hereby incorporated by reference, constitutes the entire agreement among the parties with respect to the subject matter discussed herein.
8. If one or more of the provisions of this Release shall, for any reason, be held invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect or impair any other provision of the Release. This Release shall be construed as if such invalid, illegal, or unenforceable provisions had not been contained herein.

JURUPA COMMUNITY SERVICES DISTRICT

PARKS DEPARTMENT

By: ____

Name: ____

Title: ____

Date: ____

PARENT(S) OR GUARDIAN(S)

By: ________________________________

Name: _____________________________

Relationship: _______________________

Date: ______________________________

By: ________________________________

Name: _____________________________

Relationship: _______________________

Date: ______________________________

JURUPA COMMUNITY SERVICES DISTRICT

PARKS DEPARTMENT

ALLERGY TREATMENT

TRAINING ACKNOWLEDGEMENT

I, ___________________________________, have been trained by _____________________________ (Parent(s)/Guardian(s)/Designee(s)) to administer Epinephrine and/or to provide other emergency care to __________________________ (Child's Name), a child registered in a Jurupa Community Services District (JCSD)_program, in the event the child has been exposed to or ingests _________________ and is at risk of an anaphylactic reaction, or if the child exhibits the symptoms described in the "Authorization For Emergency Care of Children with Severe Allergies," which is attached to and made a part of this Acknowledgement.

District Staff Signature: ____

Date of Training: ____

Parent(s)/Guardian(s) Signature: ____________________________________

JURUPA COMMUNITY SERVICES DISTRICT

PARKS DEPARTMENT

ACKNOWLEDGEMENT OF RECEIPT OF POLICY

FOR ADMINISTERING EMERGENCY TREATMENT

TO CHILDREN WITH SEVERE ALLERGIES

I acknowledge that I have received a copy of the Jurupa Community Services District Parks Department's Policy for Administering Emergency Treatment to Children with Severe Allergies.

Parent (s)/Guardian(s) Signature: ____________________________________

Date: ____

JURUPA COMMUNITY SERVICES DISTRICT

PARKS DEPARTMENT

POLICY FOR TESTING BLOOD GLUCOSE LEVELS

Children with insulin-dependent diabetes generally require monitoring of their blood glucose levels. Accordingly, where an enrolling/enrolled child has insulin-dependent diabetes, the following is required:

PARENT(S)/GUARDIAN(S) MUST COMPLETE AND/OR PROVIDE THE FOLLOWING:

1. A signed copy of the Jurupa Community Service District (JCSD) Parks Department's "Authorization for Care of Children with Insulin-Dependent Diabetes" (Authorization Form). This form must be filled out completely by the child's physician and Parent(s)/Guardian(s), and must be updated every six months, or more frequently, as needed. The Authorization Form is designed to provide the JCSD with the information necessary to ensure its effective care of children with insulin-dependent diabetes. In addition, the Parent(s)/Guardian(s) shall provide a copy of any other physician's orders and procedural guidelines relating to District staff's and/or volunteer's care of the child's diabetes.
2. A signed copy of the District's "Release and Waiver of Liability for Testing of Children with Insulin Dependent Diabetes" (Waiver). The Waiver releases the JCSD and its employees and volunteers from liability for administering the blood glucose test and taking any other necessary actions set forth in the Authorization Form, provided that the JCSD and its employees and volunteers exercise reasonable care in taking such actions. The Waiver further releases the District from liability for any failure to identify symptoms of hypoglycemia or hyperglycemia in their child. The Waiver further requires the Parent(s)/Guardian(s) to acknowledge that any treatment administered will not be provided by medical professionals, and that District employees and volunteers have not received any formal medical training for administering blood glucose testing, medication or identifying the symptoms of an hypoglycemia or hyperglycemia . The Waiver will also acknowledge that the District cannot provide constant monitoring of the child for the purposes of identifying symptoms of hyperglycemia and hypoglycemia (too high or too low blood sugar levels).

3. All supplemental foods and equipment necessary for the testing, including, a log book in which to record the test results and a sharps container. The Parent(s)/Guardian(s) is responsible for the maintenance of materials and equipment, including, ensuring that the blood glucose meter is in good working order.

   The District is not responsible for any damage or loss of equipment provided reasonable care is exercised in storing and using these items.

PARENT(S)/GUARDIAN(S) MUST SELECT ONE OR MORE OF THE FOLLOWING FOUR OPTIONS FOR BLOOD GLUCOSE TESTING:

1. The child may test him/herself, if old enough and authorized by the Parent(s)/Guardian(s)on the "Authorization for Care of Children with Insulin-Dependent Diabetes" (Authorization Form);
2. The Parent(s)/Guardian(s) may come to the District facilities to perform the test;
3. The Parent(s)/Guardian(s) may arrange for a third party to come to the District facility and perform the test; or
4. District staff and/or volunteers will perform the blood glucose test and take those steps needed to regulate the child's blood glucose as authorized by the Parent(s)/Guardian(s) on the Authorization Form.

   If any option other than number 4 is selected, designated District staff and/or volunteers will provide assistance to the child, the Parent(s)/Guardian(s) or the third party (e.g. in recording the test results and/or the disposal of testing equipment, including, but not limited to, sharps).

PROCEDURES FOR BLOOD GLUCOSE TESTING

If the Parent(s)/Guardian(s) elects to have District staff and/or volunteers perform the Blood Glucose Testing, the following steps must be implemented.

1. Prior to the child's first day of attendance, the Parent(s)/Guardian(s)/Designee(s) is responsible for training selected members of the District staff and/or volunteers to administer the Blood Glucose Test and, in the event that the child's blood sugar level is too high or too low, to take the appropriate steps, as set forth in the Authorization Form. In addition, all members of assigned District staff and/or volunteers will be

trained to recognize symptoms of high or low blood sugar and to take the appropriate steps for treating the child, as set forth in the Authorization Form.

2. Whenever possible, at least two (2) members of the District staff and/or volunteers will attend the training provided by the Parent(s)/Guardian(s)/Designee(s). Upon completion of the training, the District staff and/or volunteers shall complete and sign the Blood Glucose Testing Training Acknowledgement.
3. Training shall be repeated every six months, as needed, which may be or when fifty percent (50%) of the staff and/or volunteers has turned over, whichever occurs first.
4. The District will make all reasonable efforts to have at least one (1) staff member or volunteer, trained to perform the Blood Glucose Test, at all times the child is present in the class or program, however, it is not possible for the District to guarantee that a trained staff member or volunteer will be present at all times.
5. Testing equipment and used sharps shall be stored in a secure area accessible only by trained staff or other designated District employees or volunteers. During field trips, a trained member of the staff or other designated employee or volunteer shall be designated to carry any required testing equipment and food.
6. Warning signs alerting staff and/or volunteers of the child's diabetes and dietary restrictions shall be posted in the child's classroom or other location of the activity, where possible.

STEPS FOR PERFORMING BLOOD GLUCOSE TESTING AND PROVIDING APPROPRIATE FOLLOW-UP CARE:

Unless otherwise indicated on the Authorization form, blood glucose testing is performed at any time the child exhibits signs or symptoms of hyperglycemia or hypoglycemia. Signs and symptoms of hyperglycemia and hypoglycemia are listed on the attached charts. In addition, each building will be provided with a chart containing this information to be posted for staff and/or volunteer awareness.

1. The designated staff member(s) or volunteers will collect all necessary equipment/supplies for testing.
2. The child is instructed to wash his/her hands with soap and water.
3. The staff member or volunteer will wash his/her hands with soap and water and apply gloves prior to doing the testing, in accordance with OSHA requirements.

4. The child's finger will be shallowly pricked with the supplied sharps device, using caution to prick the sides of the finger. District staff or volunteers will use a different finger each day for the testing unless otherwise indicated on the Authorization Form.
5. A drop of blood will be placed on the strip and/or otherwise placed onto the meter for reading.
6. When the blood glucose test is complete, the child's finger will be covered with an adhesive bandage, and the meter and sharps device returned to the designated container. When the Parent(s)/Guardian(s) is notified that the sharps container is full, the Parent(s)/Guardian(s) will remove the container and dispose of any used sharps in the appropriate manner. **Under no circumstance are sharps to be disposed of at a District facility.**
7. The blood glucose level (number) will be entered in a log provided by the Parent(s)/Guardian(s) and the appropriate actions will be taken as set out in the Authorization Form. **If the blood glucose level (number) falls outside the target range specified in the Authorization Form, the appropriate actions will be taken and then the** Parent(s)/Guardian(s) **will be called and advised of the blood glucose number and actions taken.** [Note: Parent(s)/Guardian(s) are responsible for providing a contact number where they can be reached when necessary.] In the interim, if the child becomes lethargic, dizzy, or feels faint, District staff or volunteers will call the area's emergency personnel number (e.g. 911) and the child's doctor's office. In the event of any conflict between this policy and the instructions set forth in the Authorization Form, the instructions in the Authorization Form must be followed.

JURUPA COMMUNITY SERVICES DISTRICT

PARKS DEPARTMENT

AUTHORIZATION FOR CARE OF CHILDREN

WITH INSULIN-DEPENDENT DIABETES

Dear Doctor: ___________________________________ Date: _________________

Your patient, ____ is enrolled/enrolling in one of our District programs and we have been requested to provide blood glucose monitoring and appropriate follow-up care. Please complete Part I of this instruction record. This record will remain in the child's file at the Jurupa Community Services District so we may assist with the allergy care and needs of our enrollee and your patient. If you need to provide further instructions or clarifications, please do so on a separate sheet of paper, which will become part of this record and will be kept with this form in the child's file.

PART I (to be completed by physician)

Child's Name: ________________________________ Child's Birth Date: _____________

Target range of Blood Glucose: [ ] 70-180 [ ] 80-240 [ ] other ____ - _____

Name of blood glucose meter child is using: ___________________________________

____

Procedures

Blood glucose testing is performed at any time the child exhibits signs and symptoms of hyperglycemia or hypoglycemia, as described on the attached form. Parent(s)/Guardian(s) must supply blood glucose monitoring materials (including, but not limited to, meter and strips or chem strips, lancet, adhesive bandages, etc.). Other materials shall include (provide details) ______________________________________.

Parent(s)/Guardian(s) is responsible for providing an appropriate container for the disposal of any "sharps" items. When the Parent(s)/Guardian(s) is notified that the sharps container is full, the Parent(s)/Guardian(s) will remove the container and dispose of any used sharps in the appropriate manner. **Under no circumstance are sharps to be disposed of at District Facilities.**

ACTIONS FOR LOW BLOOD SUGAR (BELOW ______):

1. Provide the child with one of the following fast-acting carbohydrates in the following quantities (please delete those items which are not recommended): ____ ounces of apple or orange juice; _____ ounces of milk; _____ ounces of carbonated beverage with sugar; _____ hard candies; or other ________.
2. If lunch or snack is greater than one hour away, ALSO give the child one of the following in these quantities: # ____________ graham cracker squares; # ______saltine crackers; # _______ pieces of bread or toast; or other: ____________________________________.
3. Repeat blood glucose test in __________ minutes.
4. Repeat snack of fast-acting carbohydrates if symptoms persist or resume within 15 minutes.
5. If the child experiences the following symptoms, and they are not eliminated by the actions specified above, contact the Parent(s)/Guardian(s) immediately and ask him or her to come to the District facility to take the child to his/her physician:
   (Please indicate the symptoms that require parental notification)
   _____ Dizziness
   _____ Weakness
   _____ Impaired Vision
   _____ Other (explain): ____
6. If the steps outlined above do not eliminate the child's symptoms and the child experiences more serious symptoms (such as loss of consciousness or seizure), District staff and/or volunteers will call the area's emergency personnel number (e.g. 911).

7. Other (explain): ____

ACTIONS FOR HIGH BLOOD SUGAR (ABOVE ______):

1. Contact Parent(s)/Guardian(s) immediately and child's physician if blood glucose is more than ______.
2. Other (explain): ____

Recreational Activities

1. The child may participate in indoor recreational activities. [ ] Yes [ ] No
2. The child may participate in outdoor recreational activities. [ ] Yes [ ] No
3. Activity restrictions: [ ] None [ ] Some Restrictions (explain): ____

Diet Restrictions

1. Parent(s)/Guardian(s) is responsible for reviewing any snack or meal plan each week and supplying any food substitutions required for their child. District staff is responsible for notifying Parent(s)/Guardian(s) if a birthday or holiday party or any other special event involving food is planned for that week so that Parent(s)/Guardian(s) may have the option of providing a snack that meets the child's dietary restrictions.
2. Parent(s)/Guardian(s) is responsible for supplying the carbohydrate snacks which need to be given in the event of low blood sugar levels.

Child's Physician

Name: ____

Address: ____

Telephone No.: ____

Emergency Contact No.: ______________________________________

Signature: _____________________________ Date: _______________

PART II (to be completed by Parent(s)/Guardian(s))

Parent(s)/Guardian(s)

Name: ____

Address: ____

Telephone No.: ____

Emergency Contact No.: ____________________________________

Name: ____

Address: ____

Telephone No.: ____

Emergency Contact No.: ____________________________________

Indicate the person(s) who is/are authorized to conduct blood glucose testing (check all that apply).

[ ] District Staff or volunteers

[ ] Parent(s)/Guardian(s)

[ ] Child

[ ] Other: Name(s): ______________________________________

By signing this form, I/We authorize the Jurupa Community Services District staff and/or volunteers to follow the above instructions from my/our child's physician in the Authorization Form. I/We agree to update this form every six (6) months, or sooner if my/our child's needs change.

Signature: ____

Parent/Guardian

Date: ____

Signature: ____

Parent/Guardian

Date: ____

JURUPA COMMUNITY SERVICES DISTRICT

PARKS DEPARTMENT

RELEASE AND WAIVER OF LIABILITY FOR

TESTING OF CHILDREN WITH INSULIN-DEPENDENT DIABETES

This is a RELEASE AND WAIVER OF LIABILITY FOR TESTING OF CHILDREN WITH INSULIN-DEPENDENT DIABETES (herein, referred to as the "Release") made this ____ day of ______________, 20_____, by and between the Jurupa Community Services District Parks Department and ______________________________ (Parent(s)/Guardian(s)} residing at ____________________________________ (address), who are the Parent(s)/Guardian(s) of ___________________________ (child's name);

WHEREAS, the Jurupa Community Services District Parks Department provides youth programs at numerous facilities and the Parent(s)/Guardian(s) has enrolled _____________________ (child's name);

WHEREAS, the Jurupa Community Services District Parks Department has been requested by the Parent(s)/Guardian(s) to administer blood glucose testing to the child while the child participates in District programs, as prescribed in writing on the child's "Authorization for Care of Children with Insulin-Dependent Diabetes," all in accordance with and subject to District policy for Testing Blood Glucose Levels.

NOW, THEREFORE, in consideration of the agreements and covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

1. Parent(s)/Guardian(s) hereby acknowledges that the blood glucose testing administered will not be provided by medical professionals, and that District employees and volunteers have not received any formal medical training for administering blood glucose testing or other medical treatment to children suffering from insulin dependent diabetes. Parent(s)/Guardian(s) further acknowledges that the only training District employees and volunteers may receive for administering blood glucose testing and other medical treatment to his/her child is the training provided by Parent(s)/Guardian(s).

2. Parent(s)/Guardian(s) hereby acknowledges that District employees and volunteers have not received any formal medical training for identifying the symptoms of hyperglycemia or hypoglycemia (too high or too low blood sugar levels).
3. Parent(s)/Guardian(s) hereby acknowledges that while the District will make all reasonable efforts to have at least one of the employees or volunteers trained by the Parent(s)/Guardian(s) to administer blood glucose testing or other medical treatment to the child, available at all time, the District <u>cannot guarantee</u> that the staff members or volunteers will be present at all times.
4. Parent(s)/Guardian(s) hereby acknowledges that in emergency situations where District staff or volunteer which have been trained by Parent(s)/Guardian(s) to administer blood glucose testing or other medical treatment to the child in the event the child exhibits symptoms of hyperglycemia or hypoglycemia are not present and the child exhibits symptoms of hyperglycemia or hypoglycemia, blood glucose testing or other medical treatment may be administered by other District employees or volunteers.
5. Parent(s)/Guardian(s) hereby releases and forever discharges the Jurupa Community Services District and its employees, volunteers or agents from any and all liability arising in law or equity as a result of the Jurupa Community Services District's employees, volunteers or agents administering blood glucose testing and/or any other medical treatment with the testing supplies and medications provided by the Parent(s)/Guardian(s) or providing any other medical treatment or emergency care as prescribed by the child's physician as set forth in the "Authorization for Care of Children with Insulin Dependent Diabetes provided that the Jurupa Community Services District has used reasonable care in administering blood glucose testing and any medication treatment or medications or emergency care in accordance with the Authorization.
6. Parent(s)/Guardian(s) hereby releases and forever discharges the Jurupa Community Services District and its employees, volunteers or agents from any and all liability arising in law or equity as a result of the Jurupa Community Services District employees or agents failing to identify or misidentifying symptoms of hyperglycemia and hypoglycemia described by the child's physician in the "Authorization for Care of Children Insulin Dependent Diabetes provided that the Jurupa Community Services District has used reasonable care.
7. This Release supersedes and replaces all prior negotiations and all agreements proposed or otherwise, whether written or oral, concerning all subject matters covered herein. This instrument, along with the Authorization

(including, any additional physicians instructions or clarifications), which is hereby incorporated by reference, constitutes the entire agreement among the parties with respect to the subject matter discussed herein.

8. If one or more of the provisions of this Release shall, for any reason, be held invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect or impair any other provision of the Release. This Release shall be construed as if such invalid, illegal, or unenforceable provisions had not been contained herein.

JURUPA COMMUNITY SERVICES DISTRICT

PARKS DEPARTMENT

By: ______________________________________

Name: ____________________________________

Title: _____________________________________

Date: _____________________________________

PARENT(S) OR GUARDIAN(S)

By: ____________________________	By: ____________________________
Name: __________________________	Name: __________________________
Relationship: ____________________	Relationship: ____________________
Date: ___________________________	Date: ___________________________

JURUPA COMMUNITY SERVICES DISTRICT

PARKS DEPARTMENT

BLOOD GLUCOSE TESTING

TRAINING ACKNOWLEDGEMENT

I, ___________________________________, have been trained by ______________________________ (Parent(s)/Guardian(s)/Designee(s)) to test the blood sugar level and/or administer other emergency care to ___________________________ (Child's Name), a child registered in a Jurupa Community Services District Parks Department program, in the event the child exhibits symptoms of hyperglycemia or hypoglycemia (too low or too high blood sugar levels).

District Staff Signature: ____

Date of Training: ____

Parent(s)/Guardian(s) Signature: ____________________________________

JURUPA COMMUNITY SERVICES DISTRICT

PARKS DEPARTMENT

ACKNOWLEDGEMENT OF RECEIPT OF POLICY

FOR TESTING BLOOD GLUCOSE LEVELS

I acknowledge that I have received a copy of the Jurupa Community Services District Parks Department's Policy for Testing Blood Glucose Levels.

Parent (s)/Guardian(s) Signature: ______________________________________

Date: ____