DESIGNATION OF A PARENT-DESIGNATED ADULT

Washington State requires public school districts to address the medical needs of students. The school district uses this document to certify that a person intends to serve or continue to serve as a volunteer parent-designated adult pursuant to chapter 350, Laws of 2002 which added sections to RCW 28A.210.

For the purpose of this form, “parent-designated adult” means: a volunteer over 18 years of age, who may be a school district employee, who receives additional training from a health care professional or expert in **diabetes/epilepsy (circle one)** care selected by the parents, and who provides care, if needed, for the child consistent with the individual health plan. The“additional training” is for care that would otherwise be performed by a health professional licensed under RCW18.79.

A parent-designated adult, acting in good faith and in substantial compliance with the student’s individual health plan and the instructions of the student’s licensed healthcare professional, that provides assistance or services shall not be liable in any criminal action or for civil damages in his or her individual or marital or governmental or corporate or other capacities as a result of the services provided to students with diabetes/epilepsy. The designated licensed professional is not responsible for the supervision of the PDA for those procedures that cannot be delegated and are authorized by the parent for the PDA to provide.

Information

Name of Child:_______________________________ Birthdate:__________________
Address:____________________________________ Phone:_____________________
School Year:________________ School:__________________________ M/F:________
Name of PDA:________________________________ Birthdate:__________________
Address:____________________________________ Phone:_____________________
Alternate Phone:____________________________ Relationship to Child: ____________

Grant of Permission

As a parent or guardian of _______________________, a child with _______________________,
I hereby acknowledge that I have read and understand this form and agree to the following:

I hereby authorize the following people to be PDA(s) for the above-named student and empower them to provide health care to my child:

____

I further agree that if the PDA is not a district employee and does not participate in the district IHP training, I will arrange for the PDA to receive comparable training. I further agree to agree to arrange for the PDA to receive additional training for the additional care I authorize the PDA to provide, including:

____

Signature of Parent/Guardian:____________________________ Date______________

Work Phone:__________________ Home Phone: ____________________

PLEASE SIGN AND RETURN THIS FORM TO YOUR SCHOOL OFFICE.

<u>If no form is on file, it will be assumed that permission for a PDA has not been granted</u>

and there will be no PDA designated to your child.