

**I.T. Montgomery Elementary School  
Wellness Committee  
202 Martin Luther King, Jr. Road  
Mound Bayou, MS 38762-0901  
Telephone (662) 741-2433  
Fax # (662) 741-2578**

To Parents/Guardians of Children with **Diabetes/Potential Hypoglycemia:**

The Mississippi Legislature has passed an act that permits students to carry and/or self administer emergency hypoglycemic medications at school. This means that a student can keep their glucagon kit for immediate availability, when needed, provided the following conditions have been met:

1. The parent/guardian must provide **written** consent for the child to carry and/or give their own hypoglycemic medications, (when condition allows), or for a nurse, or trained principal designee to administer it , if needed.
  
2. A **written signed statement** from the student's doctor, physician assistant, or nurse practitioner indicating the following:

The student has Diabetes/ Potential for Hypoglycemia

- Has received instruction in self- administration of glucagon
- The name, purpose, and prescribed dosage of the medications
- Time, circumstances of when student is to receive medication

3. **Student must sign an agreement containing guidelines/safeguard rules for carrying glucagon.**

**Please Note: The Mound Bayou School District, it employees and agents will not be held liable for any injury sustained by the student who has self administered hypoglycemic medications.**

I give permission for my child/student to carry and self administer his/her hypoglycemic medication.

I give permission for my child/student to **CARRY** his/her hypoglycemic medication **ONLY**, I request that **nurse or principal designee** give it , if needed.

I **DO NOT** give permission for my child to **carry or self administer** his/her hypoglycemic medication.

**I acknowledge receipt of the terms and condition of the circumstances in the above information. I agree to hold the school harmless for claims and release the school, its employees, and agents from liability for any injury sustained by student as a result of self-administering hypoglycemic medication.**

**Authorization is hereby given to release this information to appropriate school personnel and classroom teachers.**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Name of Student

Date: \_\_\_\_\_

Contact phone Numbers \_\_\_\_\_