NOTICE OF FORM CHANGE NO. 05-137

DATE: 10/13/2005

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

☒ Community Care Licensing District Offices
☐ Private and Public Adoption Agencies
☐ District Attorney
☐ Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE: LIC 9222 - Blood Glucose Testing Consent/Verification Child Care Facilities

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
EACH	☒ Free ☐ Sold		☐ Yes ☒ No
☒ New ☐ Revised	DATE OF FORM: 9/05	REPLACES	☐ Obsolete

REQUIRED FORM-
☒ No Change Permitted
REQUIRED FORM-
☐ Substitute Permitted With Prior DSS Approval
☐ Recommended Form

UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT:
Department of Social Services Warehouse
P.O. Box 980788
West Sacramento, CA 95798-0788

☐ Other:

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY
☐ Use until exhausted
☐ Destroy

USE NEW FORM
☐ When supply available in DSS Warehouse
☒ Use new form effective 9/05

USE FORM IN ACCORDANCE WITH
☐ All County Letter No.
☐ Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE
Attached is a Reproducible Copy

This form is now on the internet.

Check on the internet to see if forms are available at www.dss.cahwnet.gov

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov. Contact Language Services for other languages at (916) 651-8876 or by electronic mail at LTS@dss.ca.gov.

BLOOD GLUCOSE TESTING CONSENT/VERIFICATION
CHILD CARE FACILITIES

This form may be used to show compliance with Health and Safety Code Section 1596.797 before a child care licensee or staff person performs blood glucose testing on a child in care diagnosed with diabetes. A copy of the completed form should be filed in the child's record and in the personnel file. ***A separate form must be filled out for each person who performs blood glucose testing on the child.***

I,_____, give my consent for_____,
(PRINT NAME OF AUTHORIZED REPRESENTATIVE) (PRINT NAME OF LICENSEE OR STAFF PERSON)

who work(s) at _____,
(PRINT NAME AND ADDRESS OF CHILD CARE FACILITY)

to perform blood glucose testing on my child,_____, and to contact my child's health care provider.
(PRINT NAME OF CHILD)

In addition, I certify that I have personally instructed the above-named licensee or staff person on how to perform blood glucose testing on my child.

I have also provided the child care facility with written instructions from my child's physician, or from a health care provider working under the supervision of my child's physician (for example, a physician's assistant, nurse practitioner or registered nurse). These instructions include:

- The blood glucose test must be approved by the Federal Food and Drug Administration.
- Specific written directions for performing blood glucose testing in accordance with the physician's prescription.
- Potential side effects and expected response.
- Actions to be taken in the event of side effects or incomplete treatment response in accordance with the physician's prescription. This includes actions to be taken in an emergency.
- Instructions for proper storage of the medication.
- The telephone number and address of the child's physician.

SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE

ADDRESS OF AUTHORIZED REPRESENTATIVE

HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER