CONTINUOUS GLUCOSE MONITORING
PARENTAL PERMISSION FORM

HEALTH SERVICES
SCHOOL DISTRICT U-46

Student Name: _____ ID #_____
Date of Birth: _____ Grade/Teacher: _____
Parent phone numbers (home)_____ (Cell)_____
School: _____
Brand of Continuous Glucose Monitor_____
Name of monitoring app_____

I hereby confirm that Student Diabetic Management shall be directed as written in the student's 504 accommodation plan and Physician directed Diabetic Medical Management plan. Use of continuous glucose monitoring can be used as a supplemental glucose monitoring tool during regular school hours, and I consent for the Nurse to have access to the student's Continuous Glucose Monitoring data.

I acknowledge that since WIFI is required for diabetic apps use, the District cannot guarantee continuous internet due to service interruption or internal downtime. I hereby accept all risks associated therewith.

Parents and/or Students shall be responsible for creating and maintaining correct log-ins for both WIFI to app and WIFI.

As a parent, if you receive an alert/notification concerning a high/low reading, you should notify the Nurse at your child's school immediately.
The Direct phone number for your nurse is: _____.

The Nurse will monitor for high/low alarms. An accu-check will be completed to confirm alarm and treatment will be provided as written in the Diabetic Medical Management Plan.

In the event that the nurse is absent, the substitute nurse will follow protocol laid out in the student's emergency care plan and Physician's orders.

If the CGM sensor breaks or becomes dislodged, all pieces will be collected and returned to parent. The parent will be notified by the nurse immediately.

Parent Signature: _____ Date:_____

Nurse Signature:_____ Date:_____