Accommodations Request:

Blood Glucose and Diabetes Management Plan

Child's Name: _____
School Number: _____
Director Name: _____
School Phone #: _____

☐ Prospective Enrollment

Date parent/guardian would like child to begin: _____

☐ Child Currently Enrolled

Date child began enrollment: _____

Please include the following ***completed*** information along with this coversheet:

☐ *Blood Glucose and Diabetes Management Plan*
☐ *Any other pertinent information provided by parent/guardian*

Completed packets should be returned to the school by the parents and submitted by the school to the inclusion team.

Please email the entire packet, using this page as your cover, to the Inclusion Team:

inclusionteam@learningcaregroup.com

If you must fax, send to 248-675-4940

Call Leah Riker at 248-675-0408 for questions.

POLICY FOR BLOOD GLUCOSE AND DIABETES MANAGEMENT

Children with insulin-dependent diabetes generally require a diabetes managment plan that may include blood glucose testings and other accommodations. Accordingly, when 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 Children's Courtyard's "***Authorization for Blood Glucose and Diabetes Management Plan***" (Authorization Form). This form must be filled out **completely** by the child's physician and parent(s)/guardian(s) and must be updated approximately every six months, or more frequently, as needed. The Authorization Form is designed to provide The Children's Courtyard 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 health care professional's orders and procedural guidelines relating to The Children's Courtyard's care of the child's diabetes, if any.
2. A signed copy of The Children's Courtyard's "Release and Waiver of Liability for Children with Insulin-Dependent Diabetes'" (Waiver). The Waiver releases The Children's Courtyard and its employees from liability for administering care pursuant to the diabetes management plan and taking any other necessary actions set forth in the Authorization Form, provided that The Children's Courtyard exercises reasonable care in taking such actions.

   ***Note**: The Managing Director is responsible for: (1) collecting these documents after they have been properly executed and (2) placing a copy of each form in the child's The Children's Courtyard file and sending them to the inclusion team.
3. All supplemental foods, supplies, and equipment necessary for the diabetes management, including a log book in which to record the test results and a sharps container. The parent(s)/guardian(s) are responsible for the maintenance of materials and equipment, including ensuring that the blood glucose meter is in good working order.
   The Children's Courtyard 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 AND DIABETES MANAGEMENT:

1. The child may, with the supervision of a trained school employee, test him/herself, if old enough and authorized by the parent(s)/guardian(s) on the Authorization for Blood Glucose and Diabetes Management Plan (the "Authorization Form");
2. The parent(s)/guardian(s) may come to the Center to perform blood glucose and diabetes management;
3. The parent(s)/guardian(s) may arrange for a third party to come to the Center and perform blood glucose and diabetes managment ; or
4. The Children's Courtyard Staff will perform the blood glucose and diabetes management care 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 No. 4 is selected, The Children's Courtyard Staff will provide collateral assistance to the child, the parent(s)/guardian(s) or the third party as needed (e.g. in recording the test results, the disposal of sharps, etc).

All necessary members of the staff 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.

PROCEDURES FOR BLOOD GLUCOSE AND DIABETES

MANAGMENT: If the parent(s)/guardian(s) elect to have The Children's Courtyard Staff perform the Blood Glucose and Diabetes Management, 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 working jointly with the school to arrange training for selected members of the Staff including, but not limited to, the Director, Assistant Director, and Child's Teacher(s), with respect to the child's Blood Glucose and Diabetes Medical Management Plan. The training should be conducted by a qualified health care provider or diabetes educator, and include hands on training for blood glucose testing, and, where relevant, managing insulin levals (by calculating insulin dosage and administering insulin), proper sharp disposal, as well as taking other appropriate measures, as set forth in the Authorization form. In addition, necessary members of the Staff 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. At least four (4) members of The Children's Courtyard Staff including, but not limited to, the Director, Assistant Director, and Child's Teacher(s), shall attend the training provided by a physician, physician's assistant, or nurse. Upon completion of the training, the Staff shall complete and sign the Blood Glucose and Diabetes Management Training Acknowledgment.

3. Training shall be repeated every six months, or when fifty percent (50%) of The Children's Courtyard Staff has turned over, whichever occurs first. If the individual serving as the Director, the Assistant Director, and/or the child's teacher(s) is replaced, his or her replacement shall immediately be trained by the parent(s)/guardian(s)/designee(s).

4. At least one (1) Staff member trained to perform the Blood Glucose and Diabetes Management shall be present at all times the child is present at the Center and shall accompany the child on all field trips.

5. Testing equipment and used sharps shall be stored in a secure area accessible only by trained Staff. During Center field trips a trained member of the Staff shall be designated to carry any required testing equipment, food, and sharps disposal containers.

6. Warning signs alerting Staff of the child's diabetes and dietary restrictions shall be posted in the kitchen, the child's classroom, and may be listed on other school documentation.

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

Blood glucose monitoring and other diabetes management will be performed as specified in the child's individualized Blood Glucose and Diabetes Management Plan. Signs and symptoms of hyperglycemia and hypoglycemia are listed on the attached chart. In addition, each Center will be provided with a chart containing this information to be posted for Staff awareness. Generally, the following steps will be followed, unless other instructions are provided in the child's Blood Glucose and Diabetes Managment Plan.

1. The designated Staff member(s) will collect all necessary equipment/supplies.

2. Staff will ensure that the child washes his/her hands with soap and water.

3. The Staff member will wash his/her hands with soap and water and apply gloves, 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. Staff will use a different finger each day for the testing unless otherwise indicated on the child's individualized Blood Glucose and Diabetes Management Plan.

5. When the blood glucose test is completed, 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 the Center.

6. The blood glucose level (number) will be entered on a log provided by the parent(s)/guardian(s) and the appropriate actions will be taken as set out in the Blood Glucose and Diabetes Management Plan. **If the blood glucose level (number) falls outside the target range specified in the plan, 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, 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 document and the instructions set forth in the Blood Glucose and Diabetes Management Plan, the instructions in the plan **must** be followed.

7. Insulin dose will be calculated and insulin administered in accordance with the Blood Glucose and Diabetes Management Plan, and policies on first aid and medication.

8. For insulin delivery via pump or pen, parent(s)/guardian(s) shall provide the Center with manufacturer information to ensure proper use.

HYPOGLYCEMIA (LOW BLOOD SUGAR)

Signs and Symptoms:

Shaking	Sleepiness	Extreme tiredness/fatigue
Nervous/anxious	Changed Behavior	Inability to Swallow
Increased Sweating	Paleness	Sudden Crying
Blurred Vision	Dilated Pupils	Restlessness
Increased Hunger	Increased Heart-Rate or Palpitations	Dazed Appearance
Fatigue/Weakness	Yawning	Seizures
Confusion/Loss of Consciousness	Irritability/Frustration	

Causes: skipping meals, too much insulin, too much exercise

Treatment: Have child eat or drink something that is high in sugar content, i.e., apple juice, orange juice, carbonated beverage, milk.

HYPERGLYCEMIA (HIGH BLOOD SUGAR)

Signs and Symptoms:

Increased Thirst	Lack of Concentration	Weight loss
Increased Hunger	Profound Weakness	Stomach Pains
Increased Urination	Confusion	Flushing of Skin
Blurred Vision	Dry Mouth	Fatigue/Sleepiness
"Fruity" Smell to Breath	Stomach Cramps	Vomiting
Nausea	Loss of Consciousness	Labored Breathing

Causes: skipping insulin, too much food

Treatment: Because the child may need an insulin injection, contact the parents or the child's physician immediately.

The Children's Courtyard

AUTHORIZATION FOR BLOOD GLUCOSE AND DIABETES MANAGEMENT PLAN

Dear Doctor _____ **Date** _____

Your patient, _____, is enrolled/enrolling in our Center and we have been requested to provide blood glucose and diabetes management and appropriate follow-up care. Please complete Part I of this instruction record. This record will remain in the child's file at The Children's Courtyard so we may assist with the blood glucose and diabetes managment and other 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 a part of this record and will be kept with this form in the child's file at The Children's Courtyard .

PART I BLOOD GLUCOSE AND DIABETES MANAGMENT PLAN (to be completed by physician**)**

Child's Name:_____ Child's Birth Date: _____

Date of diabetes diagnosis: _____

Target range of blood glucose: [ ] 70-180 [ ] 180-240 [ ] other_____- _____

Name of blood glucose meter child is using: _____

PROCEDURES

Blood glucose and diabetes management is performed before lunch and, in addition, 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 (meter and strips or chem-strips, lancet, adhesive bandages, etc.).
Other materials shall include (give detail) _____
Parent(s)/guardian(s) are 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.

CHECKING BLOOD GLUCOSE

Brand/model of blood glucose meter:
_____ **Target range of blood glucose:**
Before meals: [ ]90–130 mg/dL [ ]Other: _____
Check blood glucose level:

[ ] Before breakfast [ ] After breakfast [ ] ___ hours after breakfast
[ ] Before lunch [ ] After lunch [ ] ___ hours after lunch
[ ] Mid-morning [ ] Before physical activity [ ] After physical activity
[ ] 2 hours after correction dose [ ] other: _____

[ ] As needed for signs/symptoms of low or high blood glucose
[ ] As needed for signs/symptoms of illness
Preferred site of testing: [ ] Side of fingertip [ ] other: _____
Note: The side of the fingertip should always be used to check blood glucose level is hypoglycemia is suspected. **Student's self-care blood glucose checking skills:**
[ ] Independently checks own blood glucose [ ] May check blood glucose with supervision
[ ] Requires trained personnel to check blood glucose
[ ] Uses smartphone or other monitoring technology to track blood glucose values

Continuous Glucose Monitor (CGM): [ ] Yes [ ] No Brand/model: _____
Alarms set for: Severe Low: _____ Low:_____ High:_____
Predictive alarm: Low: _____ High:_____ Rate of Change: Low:_____ High:_____
Threshold suspend setting: _____
Student's Self-Care CGM Skills

Student troubleshoots alarms and malfunctions. [ ] Yes [ ] No

Student knows what to do and is able to deal with a HIGH alarm. [ ] Yes [ ] No

Student knows what to do and is able to deal with a LOW alarm. [ ] Yes [ ] No

Student can calibrate the CGM. [ ] Yes [ ] No

Student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level. [ ] Yes [ ] No
Other instructions:_____

ACTIONS FOR HYPOGLYCEMIA (LOW BLOOD SUGAR) (BELOW _____);

1. Student's usual symptoms of hypoglycemia: _____
   If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL, give one of the following fast-acting carbohydrates in the following quantities (please delete those items which are not recommended): _____oz. apple or orange juice; _____ oz. milk; _____oz. carbonated beverage with sugar: hard candies. 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; #_____saltines; # _____pieces of bread or toast; or other: _____.
3. Recheck blood glucose test in 15 minutes and repeat treatment if blood glucose level is less than ____ mg/dL.
4. 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 Center to take the child to his/her physician:
   (Please indicate the symptoms that require parental notification.)
   _____Dizziness
   _____ Weakness
   _____ Impaired Vision
   _____ Other: _____
5. If the steps outlined above do not eliminate the child's symptoms, The Children's Courtyard staff will notify the child's parents/guardians.
   If child experiences more serious symptoms (such as loss of consciousness or seizure), The Children's Courtyard Staff will:
   - Position the student on his or her side to prevent choking.
   - Give glucagon: [ ] 1 mg [ ] 1/2 mg [ ] other dose_____
   -Route: [ ] subcutaneous (SC) [ ] intramuscular (IM)
   - Site for glucagon injuection: [ ] buttocks [ ] arm [ ] thigh [ ] other_____ - Call 911 Emergency Medical Services and the student's parents/guardians.

ACTIONS FOR HIGH BLOOD SUGAR (ABOVE_____);

1. Student's usual symptoms of hyperglycemia: _____
2. Check [ ] urine [ ] blood for keytones every ____ hours when blood glucose levels are above _____ mg/dL.
3. For blood glucose greater than _____ mg/dL AND at least ___ hours since last insulin dose, give correction dose of insulin (see correction dose orders).
4. Notify parents/guardians if blood glucose over _____ mg/dL
5. Allow unrestricted access to the bathroom.
6. Give extra water and/or non-sugar-containing drinks (not fruit juices): ____ ounces per hour.

INSULIN THERAPY

Insulin delivery device: [ ] syringe [ ] insulin pen [ ] insulin pump

Type of insulin therapy at school: [ ] adjustable (basal-bolus) insulin [ ] fixed insulin therapy [ ] no insulin

Adjustable (Basal-bolus) Insulin Therapy

- Carbohydrate Coverage/Correction Dose: Name of insulin: _____ **- Carbohydrate Coverage:**

Insulin-to-carbohydrate ratio: lunch: 1 unit of insulin per ___ grams of carbohydrate
breakfast: 1 unit of insulin per ___ grams of carbohydrate
snack: 1 unit of insulin per ___ grams of carbohydrate

Carbohydrate Dose Calculation Example
$\frac{\textit{Total Grams of Carbohydrate to Be Eaten}}{\textit{Insulin-to-Carbohydrate Ratio}} = \_\_\_\_\ \textit{Units of Insulin}$

Correction dose: blood glucose correction factor (insulin sensitivity factor) = _____ Target blood glucose =_____ mg/dL

Correction Dose Calculation Example
$\frac{\textit{Current Blood Glucose} - \textit{Target Blood Glucose}}{\textit{Correction Factor}} = \_\_\_\_\ \textit{Units of Insulin}$

Correction dose scale (use instead of calculation above to determine insulin correction dose):

Blood glucose ___ to ___, give ____ units
Blood glucose ___ to ___, give ____ units
Blood glucose ___ to ___, give ____ units
Blood glucose ___ to ___, give ____ units

When to give insulin:

Breakfast

[ ] Carbohydrate coverage only
[ ] Carbohydrate coverage plus correction dose when blood glucose is greater than ___ mg/dL and ____ hours since last insulin dose.
[ ] Other: _____

Lunch

[ ] Carbohydrate coverage only
[ ] Carbohydrate coverage plus correction dose when blood glucose is greater than ___ mg/dL and ____ hours since last insulin dose.
[ ] Other: _____

Snack

[ ] No coverage for snack
[ ] Carbohydrate coverage only
[ ] Carbohydrate coverage plus correction dose when blood glucose is greater than ___ mg/dL and ____ hours since last insulin dose.
[ ] Correction dose only: For blood glucose greater than ___mg/dL AND at least ___ hours since last insulin dose.
[ ] Other: _____

Fixed Insulin Therapy: Name of insulin: _____

[ ] ___ units of insulin given pre-breakfast daily
[ ] ___ units of insulin given pre-lunch daily [ ]
___ units of insulin given pre-snack daily [ ]
Other: _____

Parents/Guardians Authorization to Adjust Insulin Dose

[ ] Yes [ ] No Parents/guardians authorization should be obtained before adminsitering a correction dose.
[ ] Yes [ ] No Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/- _____units of insulin.
[ ] Yes [ ] No Parents/guardians are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: _____units per prescribed grams of carbohydrate, +/- ____ grams of carbohydrate.
[ ] Yes [ ] No Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/- _____units of insulin.

Participant's self-care insulin administration skills:

Independently calculates and gives own injections [ ] yes [ ] no

May calculate/give own injections with supervision [ ] yes [ ] no

Other: _____

Additional Information for Participant with Insulin Pump

1. Brand/Model of pump_____
2. Type of insulin in pump_____
3. Basal rates during school: Time:_____ Basal rate:_____ Time:_____ Basal rate:_____
   Time:_____ Basal rate:_____ Time:_____ Basal rate:_____ Time:_____ Basal rate:_____
   Other pump information_____

Type of infusion set: _____
Appropriate infusion site(s): _____
[ ] For blood glucose greater than ___ mg/dL that has not decreased within ___ hours after correction, consider pump failure or fusion site failure. Notify parents/guardians.
[ ] For infusion site failure: insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.
[ ] For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen.

Physical Activity

May disconnect from pump for sports activites: [ ] yes, for ___ hours		[ ] no
Set a temporary basal rate: Suspend pump use:	[ ] yes, ____% temporary basal rate for ___hours [ ] yes, for ___ hours	[ ] no [ ] no

Student's self-care pump skills	Independent?	
Counts carbohydrates	[ ] Yes	[ ] No
Calculates correct amount of insulin for carbohydrates consumed	[ ] Yes	[ ] No
Administers correction bolus	[ ] Yes	[ ] No
Calculates and sets basal profiles	[ ] Yes	[ ] No
Calculates and sets temporary basal rate	[ ] Yes	[ ] No
Changes batteries	[ ] Yes	[ ] No
Disconnects pump	[ ] Yes	[ ] No
Reconnects pump to infusion set	[ ] Yes	[ ] No
Prepares reservoir, pod, and/or tubing	[ ] Yes	[ ] No
Inserts infusion set	[ ] Yes	[ ] No
Troubleshoots alarms and malfunctions	[ ] Yes	[ ] No

Meal Plan

Meal/Snack	Time	Carbohydrate Content (Grams)
Breakfast	_____	_____ to _____
Mid-morning snack	_____	_____ to _____
Lunch	_____	_____ to _____
Mid-Afternoon Snack	_____	_____ to _____

Recreational Activities

1. The child may participate in recreational activities. [ ] Yes [ ] No
2. Activity restrictions: [ ]None [ ] Some Restrictions
   (Explain): _____
   _____

Diet Restrictions

1. Parent(s)/guardian(s) are responsible for reviewing The Children's Courtyard's menu plan each week and supplying any food substitutions required for their child. The Children's Courtyard 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) are responsible for supplying the carbohydrate snacks which need to be given in the event flow 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 and diabetes management. (Check all that apply.)

[ ] The Children's Courtyard Personnel
[ ] Parent(s) or Guardian(s)
[ ] Child
[ ] Other Names: (l) _____
(2) _____

By signing this form, I/We authorize The Children's Courtyard to follow the above instructions in the Blood Glucose and Diabetes Management Plan. I/We agree to update this plan 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 CHILDREN WITH INSULIN-DEPENDENT DIABETES

THIS IS A RELEASE AND WAIVER OF LIABILITY FOR CHILDREN WITH INSULIN-DEPENDENT DIABETES (hereinafter, referred to as the "Release")

made this_____day of, 20_____, by and between The Children's Courtyard, Inc.

("The Children's Courtyard ")
and_____
(Parent(s)/Guardian(s))

residing at_____, who are the Parent(s)/Guardian(s)
(Address)

of_____;
(Child's Name)

WHEREAS, The Children's Courtyard provides child care services at numerous facilities across the country and the Parent(s)/Guardian(s) has engaged The Children's Courtyard to provide child care for_____ (Child's Name)

WHEREAS, The Children's Courtyard has been requested by the Parent(s)/Guardian(s) to provide blood glucose and diabetes managment to their child at certain times while their child is enrolled in the Center and take certain actions as prescribed in writing on the child's "Blood Glucose and Diabetes Management Plan," all in accordance with and subject to The Children's Courtyard's Policy for Blood Glucose and Diabetes Management.

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 releases and forever discharges The Children's Courtyard and its employees or agents from any and all liability arising in law or equity as a result of The Children's Courtyard's employees or agents performing with "reasonable care" blood glucose and diabetes management and/or taking actions in conformance with the child's "Authorization for Blood Glucose and Diabetes Management" (hereinafter referred to as "Authorization"), Parent(s)/Guardian(s) also hereby releases and forever discharges The Children's Courtyard from any loss or damage incurred in the exercise of reasonable care to any material and/or equipment supplied by the Parent(s)/ Guardian(s) in connection with the blood glucose and diabetes management.
2. This Release shall be governed by the laws of the State of , which is the location of The Children's Courtyard facility in which the child is enrolled, excluding its choice of law Provisions.
3. 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 physician's instructions or clarifications), which is hereby incorporated by reference, constitutes the entire agreement among the parties with respect to the subject matters discussed herein.
4. The reference in this Release to the term The Children's Courtyard shall include its affiliates, successors, Directors, officers, employees and representatives. The terms Parent(s)/Guardian(s)

shall include the dependents, heirs, executors, administrators, assigns and successors or each.

5. 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.

The Children's Courtyard, Inc.

By: _____

Name: _____

Title: _____

Date: _____

PARENT(S) OR GUARDIAN(S)

By: _____

Name: _____

Relationship: _____

Date: _____

By: _____

Name: _____

Relationship: _____

Date: _____

Blood Glucose and Diabetes Managment Training Acknowledgment

I, _____, have been trained by

_____to provide blood glucose
(Physician, Physician's Assistant, or Nurse)

and diabetes managment to_____
(Child's Name)

an insulin-dependent diabetic child enrolled at Children's Courtyard .

Signature: _____
(CCY Employee)

Date of Training: _____

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

Acknowledgment of Receipt of Policy for Blood Glucose and Diabetes Managment

I acknowledge that I have received a copy of The Children's Courtyard's Policy for Blood Glucose and Diabetes Management.

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

Date: _____