



Medical Conditions Package for Parents & Guardians

Diabetes

Revised August 2022

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PARENT/GUARDIAN INFORMATION AND RESPONSIBILITIES DIABETES MANAGEMENT PROTOCOL

INTRODUCTION:

A review of the HCDSB Diabetes Protocol has taken place to address the components of Ministry of Education Policy/Program Memorandum #161 Supporting Children and Students with Prevalent Medical Conditions (Type 1 and Type 2 Diabetes) in Schools.

ACCESS TO THE HCDSB DIABETES PROTOCOL:

The Diabetes Management Protocol, Parent/Guardian Information Package and Type 1 Diabetes video is accessible to parents/guardians on the HCDSB Board's website: www.hcdsb.org+ PARENTS + Your Child's Health + Medical Conditions + Diabetes

ROLE OF PARENT/GUARDIAN WITH SCHOOL:

In order for School Staff to provide a safe and nurturing environment for students managing their Type 1/Type 2 Diabetes, parents/guardians are asked to:

☐ **PROVIDE proof of diagnosis for your child which can be ONE of:**

- a letter/note from the physician or specialist, OR
- a copy/photocopy of the prescription

☐ **PROVIDE information about medications, where applicable, if/when taken and any side effects:**

- a) Management medications administered to control blood sugar (e.g., insulin)
- b) Emergency rescue medication: Glucagon intranasal spray (e.g., Baqsimi™) is administered in a low blood sugar emergency (severe hypoglycemia) where the child is unable to eat or drink and is unresponsive/unconscious

Process to Follow:

- Request from the parent/guardian and prescription from a physician or other health care professional must be submitted in writing to the school principal.
- Authorization from the school principal.
- Information about the administration of the glucagon intranasal spray emergency rescue medication to be included on the Student Plan of Care.
- Parent/guardian must provide the medication to the school. Check expiry date.
- The glucagon nasal spray medication will be stored in a secure and accessible location in the school (e.g., office, health room). Only when specifically requested by the parent/guardian, the student takes responsibility for carrying the glucagon intranasal spray medication (e.g., in a fanny pouch) while on school site.

☐ **COMPLETE and return the following forms found in this package:**

☐ **STUDENT PLAN OF CARE**

- Parents/guardians of newly registered or newly diagnosed students shall create the Student Plan of Care in consultation with the school administration during the last week of August. For students already registered, the Student Plan of Care will be reviewed and/or updated annually and shared with the school before the start of each school year.

☐ **REQUEST AND CONSENT FOR THE ADMINISTRATION OF DIABETES INTERVENTION(S)/MEDICATION(S) FORM**

- Form is completed by parent/guardian when the school agrees with the parent/guardian request to provide medical intervention and/or medication under the listed conditions of the form.

Please Note: Urgency of completing forms as soon as possible:

To act in the best interest of your child/the student responding to a reaction, parents/guardians are strongly encouraged to provide all relevant information and forms to manage your child's Type 1/Type 2 Diabetes to the school principal in a timely manner. Failure to do so may place your child at unnecessary risk.

☐ **COMMUNICATE with school administrator when child requires professional health services within the school setting to assist with management protocols:**

Procedures:

- Arrange meeting with principal to discuss.
- Complete an application form for the Local Health Integration Network (LHIN) (formerly Community Care Access Centre (CCAC)).
- Completed application form forwarded to the principal by LHIN/parent/guardian.
- A LHIN Case Manager will contact parent/guardian and principal and complete an assessment of the child's health care needs in the school setting.
- A multidisciplinary conference may be required to identify the needs at school and to determine eligibility for LHIN services.
- On admission, goals will be determined and a service plan developed to ensure the safest possible learning environment for your child.
- On occasion, there may be a waiting period for some services, and/or a lack of availability of service providers. In these circumstances, the LHIN will work with parents/guardians and school staff to develop a safe plan for the child.

☐ **UPDATE Changes of information: Emergency Contact, medication, medical diagnosis:**

Parents/guardians are responsible to inform school administration of any changes to contact information, medication or medical condition diagnosis as soon as is reasonably possible. Forms can be accessed through the school office or online.

NOTE: Changes to your child's diagnosis must be accompanied by a note/letter from your child's healthcare professional indicating the change.

☐ **COMMUNICATE with secondary school when child is graduating from Grade 8:**

You will receive from your elementary school in June, a recent copy of your child's Diabetes Student Plan of Care. You are requested to update the form with recent medical and contact information and to provide the completed form to the secondary school administrator/designate during the last week of August.

☐ **PROVIDE a constant supply of fast-acting sugar to prevent and treat low blood sugar.**

☐ **PROVIDE, when appropriate, an extra snack (e.g., trips).**

☐ **PROVIDE a clearly labelled (student name, address) container** which includes blood glucose monitoring items and insulin injection items and medication.

☐ **CONSIDER providing a MedicAlert bracelet or necklace for your child** and discuss the importance of wearing it. The form can be obtained by calling 1-800-668 1507 or visit www.medicalert.ca

PARENT/GUARDIAN RESPONSIBILITIES WITH THEIR CHILD:

Communicate the following information and responsibilities to your child in managing their diabetes. Review with your child when appropriate.

- ☐ Provide age-appropriate understanding of their diabetes, how to recognize the symptoms of a low blood sugar and high blood sugar and how to take age-appropriate action to treat the symptoms.

- ☐ Provide age-appropriate information on how to administer the blood sugar monitoring system, blood testing, insulin injection, safe disposal of lancets and needles, how to manage and use appropriately the insulin pump (e.g., administering a bolus dose).
- ☐ The importance of carrying/having immediate access to their blood sugar testing kit, fast-acting sugar and insulin injection apparatus at all times.
- ☐ The importance of eating all and only what parents/guardians have approved.
- ☐ Strategies on how to deal with and resist peer pressure to 'try' something.
- ☐ Inform, check and review, when necessary, with their child the location of their blood sugar testing kit, insulin injection apparatus and fast-acting sugar during the school day and at school sponsored activities.
- ☐ Remind the child, prior to leaving for school, to check that the container for carrying (e.g., 'fanny pack', purse) contains the blood sugar testing kit, insulin apparatus and fast-acting sugar.
- ☐ Talk to their friends about their diabetes and let them know how they can help them.
- ☐ Inform child that when they are feeling unwell to never remove themselves to a secluded area or go off to be by themselves (e.g., washroom).
- ☐ Tell a teacher or classmate when they are having difficulty and need help.
- ☐ Communicate with parents/guardians and school staff if they are facing challenges related to their diabetes, including any and all teasing, bullying, threats or any other concerns they have.
- ☐ Consider providing a MedicAlert bracelet or necklace for your child. The form can be obtained by calling 1-800-668 1507 or visit www.medicalert.ca.

STUDENT RESPONSIBILITIES (ELEMENTARY AND SECONDARY):

- ☐ Where appropriate participate in the meetings for the development and review of your Plan of Care.
- ☐ Recognize your symptoms of a low blood sugar and high blood sugar and how to take age-appropriate action to treat the symptoms.
- ☐ Eat all and only what parents/guardians have approved.
- ☐ Check prior to leaving home that you have your blood sugar testing kit, insulin apparatus and fast-acting sugar.
- ☐ Take responsibility for carrying and looking after your blood sugar testing kit and insulin injection apparatus and fast-acting sugar during the school day and at school sponsored activities.
- ☐ Carry out daily or routine self-management of your diabetes as described in the Plan of Care.
- ☐ Take responsibility for advocating for personal safety and well-being.
- ☐ Check that your blood sugar testing kit, insulin injecting apparatus and fast-acting sugar is always accessible to your location (age-appropriate).
- ☐ Know (in age-appropriate ways) how to administer the blood sugar monitoring system, blood testing, insulin injection, safe disposal of lancets and needles, how to manage and use appropriately the insulin pump (e.g., administering a bolus dose).
- ☐ Where appropriate, set goals on an on-going basis for self-management of your diabetes.
- ☐ Promptly inform an adult that you have diabetes as soon as symptoms appear or when experiencing a general feeling of 'unwellness'.
- ☐ Never isolate yourself when checking blood sugar or feeling unwell.
- ☐ Communicate with parents/guardians and school staff if you are facing challenges related to your diabetes, including any, and all, teasing, bullying, threats, or any other concerns you have.
- ☐ Wear/carry medical alert identification when parent/guardian deems appropriate.
- ☐ The glucagon nasal spray medication will be stored in a secure and accessible location in the school (e.g., office, health room). Only when specifically requested by the parent/guardian, the student takes responsibility for carrying glucagon intranasal spray medication (e.g., in a fanny pouch) while on school site.

SCHOOL FORMS:

☐ TYPE 1/TYPE 2 DIABETES IDENTIFICATION AND EMERGENCY TREATMENT PLAN

- ☐ To identify your child to others, this form will be created from information included in the Student Plan of Care, by the school administrator, and will be shared with appropriate school staff and posted in your child's classroom. This form will also be provided to Halton Student Transportation Services (HSTS) where applicable.

☐ AT-A-GLANCE TYPE 1/TYPE 2 DIABETES IDENTIFICATION

- To identify your child to others, an At-A-Glance document is created, by the school administrator, which includes the student's name, grade, picture, and medical condition only that is only posted in pertinent staff areas (e.g., staff room, health room).

TYPE 1/TYPE 2 DIABETES STUDENT PLAN OF CARE

Place Student Photo Here

(PLEASE PRINT)

Student Name _____ Date of Birth _____

Grade _____ Room # _____

Medic Alert ID: Y N

Emergency Contacts (list in priority of contact) (Please print):

	Name	Relationship	Daytime Phone	Alternate Phone
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

ROUTINE

MANAGEMENT

ROUTINE	MANAGEMENT
1. BLOOD SUGAR CHECKING <input type="checkbox"/> My child can independently check blood sugar/read meter <input type="checkbox"/> My child needs supervision to check blood sugar/read meter Supervisor: _____ *Students should be able to check blood sugar anytime, anyplace, respecting their preference for privacy.	Blood Sugar Checking Times: _____ Target Blood Sugar Range: _____ <i>Call parent/guardian if blood sugar</i> _____ Location of fast-acting sugar at the school: _____
2. LUNCH/NUTRITION BREAKS <input type="checkbox"/> Student requires supervision during meal times to ensure completion (based on age/developmental ability) <input type="checkbox"/> Student can independently manage his/her food intake <input type="checkbox"/> Student must be given the time and able to eat as needed	Recommended times for meals and snacks: _____ _____ _____ Special Instructions for meal days and special events: _____ _____ _____
3. INSULIN <input type="checkbox"/> My child does not take an insulin injection at school <input type="checkbox"/> My child takes insulin at school <input type="checkbox"/> by injection <input type="checkbox"/> by insulin pump Insulin is given by <input type="checkbox"/> Student <input type="checkbox"/> Student with supervision <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Trained Individual	<input type="checkbox"/> Location of insulin: _____ <input type="checkbox"/> Required times for insulin: _____ NOTE: Educators do not give injections or operate insulin pump

Cont. ...

ROUTINE	MANAGEMENT
4. ORAL MEDICATION <input type="checkbox"/> My child does not take oral medication <input type="checkbox"/> Student takes medication with supervision	Name of medication: _____ List time(s) medication is to be taken: _____ List side effects that may affect child's day at school: _____
5. PHYSICAL ACTIVITY PLAN Physical activity lowers blood sugar and is often checked before activity. Child's blood testing metre kit and fast-acting sugar should always be on hand during physical activities.	Please indicate what your child must do prior to exercise to help prevent a low blood sugar (e.g., take juice) 1. Before activity: _____ 2. During activity: _____ 3. After activity: _____ For special events, notify parents/guardians in advance so that appropriate adjustments can be made. (e.g., extracurricular, charity runs, Play Days, long walks etc.)
6. ILLNESS	Call parent/guardian if student vomits. If child continues to vomit and parents/guardians cannot be reached: _____ _____
7. DIABETES MANAGEMENT KIT Parents/guardians must provide and maintain supplies. This kit must be accessible at all times. (e.g., field trips, fire drills, lockdowns) The school must advise parents/guardians when supplies are low.	Location of Kit: _____ Kit will include: <input type="checkbox"/> Blood Glucose meter, test strips, lancets <input type="checkbox"/> Insulin and insulin pen supplies <input type="checkbox"/> Sources of fast-acting sugar (e.g., juice, candy, glucose tabs) <input type="checkbox"/> Carbohydrate containing snacks <input type="checkbox"/> Alcohol wipes <input type="checkbox"/> Other _____
8. ADDITIONAL INFORMATION A student with special considerations may require more assistance than outlined in this plan.	Notes:
<u>EMERGENCY PROCEDURE</u> In the event of an emergency and student is unconscious/unresponsive/unable to take food/drink (fast-acting sugar)	<u>EMERGENCY PROCEDURE</u> <input type="checkbox"/> Call 911 immediately <input type="checkbox"/> Where parent/guardian has provided a glucagon intranasal spray: <ul style="list-style-type: none"> ○ Administer glucagon intranasal spray (located in health room unless otherwise specified, e.g., fanny pack) <input type="checkbox"/> Advise EMS of use of emergency rescue medication <input type="checkbox"/> Call parent/guardian

IDENTIFICATION AND EMERGENCY TREATMENT PLAN - HYPOGLYCEMIA (LOW BLOOD SUGAR)

SIGNS AND SYMPTOMS OF A LOW BLOOD SUGAR ARE: (Check (✓) all that apply)

- | | | | | |
|--|------------------------------------|---|---|-----------------------------------|
| <input type="checkbox"/> Sweating | <input type="checkbox"/> Trembling | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mood changes | <input type="checkbox"/> Confused |
| <input type="checkbox"/> Hunger | <input type="checkbox"/> Headaches | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Extreme tiredness / paleness | |
| <input type="checkbox"/> Other, please specify _____ | | | | |

If the student exhibits any of the above symptoms or feels unwell, looks unwell or says they are “low”

- DO NOT leave the student alone
- DO NOT allow the student to use stairs

ACTION

Ask student to check their blood sugar

If the reading is **below 4.0** on the meter give **fast-acting sugar immediately:**

3 glucose tablets or 6oz (175 ml) of juice/pop (not diet)

5 - 6 lifesavers or _____

If student is unable to check blood sugar, provide fast-acting sugar (see above)

Wait 15 minutes. Repeat blood sugar check

If blood sugar is still below **4.0** repeat above ACTION and call parent/guardian

If blood sugar is above **4.0** and next meal/snack is greater than 1 hour away, follow-up with a snack (provided by parent/guardian), otherwise no further action required

WHEN TO CALL 911

If student is...

Unresponsive, Unconscious, Having a Seizure

1. Roll student on their side
2. Call 911
3. Inform EMS student has Type 1 Diabetes
4. Notify parents/guardians

Unwell, Vomiting

1. Notify parents/guardians
2. Call 911 (if unable to contact parents/guardians)
3. Inform EMS student has Type 1 Diabetes

DO NOT give food or drink

IDENTIFICATION AND EMERGENCY TREATMENT PLAN – SEVERE HYPOGLYCEMIA (LOW BLOOD SUGAR EMERGENCY)

In the event of an emergency and student is unconscious/ unresponsive/unable to take food/drink (e.g., fast-acting sugar).

- Where the parent/guardian request has been granted by Principal for glucagon intranasal spray to be administered:
 - *Trained staff administer glucagon intranasal spray
 - 911 is called immediately when glucagon intranasal spray is administered. Advise EMS of use of rescue medication.
 - Call parent/guardian.

*A school administrator plus minimum of two school staff who are trained (e.g., classroom teacher, first aid provider, other school staff) are eligible to administer glucagon intranasal spray.

IDENTIFICATION AND EMERGENCY TREATMENT PLAN - HYPERGLYCEMIA (HIGH BLOOD SUGAR)

SIGNS AND SYMPTOMS OF A HIGH BLOOD SUGAR ARE: (Check (✓) all that apply)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Extreme thirst | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Frequent urge to urinate | <input type="checkbox"/> Tiredness/weakness |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Hungry | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Warm/Flushed Skin | |
| <input type="checkbox"/> Other, please specify _____ | | | |

If the student exhibits any of the above symptoms:

- Ask student to check their blood sugar
- If blood glucose is greater than _____ notify parent/guardian
- If unable to check blood sugar remain with student and call parent/guardian

ACTION

Provide extra water

Allow student to have open bathroom privileges

SIGNS AND SYMPTOMS OF HYPERGLYCEMIA EMERGENCY:

- | | | |
|--|--|---|
| <input type="checkbox"/> nausea and vomiting | <input type="checkbox"/> severe abdominal pain | <input type="checkbox"/> rapid, shallow breathing |
| <input type="checkbox"/> increasing sleepiness or lethargy | <input type="checkbox"/> other _____ | |

Steps to take for severe Hyperglycemic:

When blood sugar is at or above: _____

ACTION:

Prescribed Medications for the Management of Low/High Blood Sugar:

Medication	Dose	Circumstances medication should be administered	Additional Instructions
1.			
2.			
3.			

CONSENT FOR STUDENT TO CARRY AND SELF-ADMINISTER DIABETES INTERVENTION MEDICATION(S)

We agree that _____:
(Student Name)

- ☐ Can **carry** their prescribed Diabetes Intervention Medication while at school and during school-related activities.
Exception: My child is in Kindergarten, so theirs will be with the teacher at all times. _____ (Parent/Guardian Initial)
- ☐ Can **self-administer** their prescribed Diabetes Intervention Medication while at school and during school-related activities.
- ☐ **Requires assistance** with administering their prescribed Diabetes Intervention Medication while at school and during school-related activities.
- ☐ We will inform the school of any change in medication or delivery device. The medications **cannot** be beyond the expiration date.

Parent/Guardian Name: _____
(Please print) (Signature)

Date: _____

Student Name: _____
(18 yrs. or older) (Please print) (Signature)

Date: _____

EMERGENCY RESCUE MEDICATION:

Has an emergency rescue medication been prescribed? ☐ Yes ☐ No

If Yes, has the parent/guardian request for their child to be administered the glucagon intranasal spray (e.g., Baqsimi™) emergency rescue medication received authorization from the school principal? ☐ Yes ☐ No

Location of Rescue Medication:

- Emergency rescue medication will be stored in a secure and accessible location in the school (e.g., office, health room).
- Only when specifically requested by a parent/guardian, the student will carry their prescribed emergency rescue medication while at school (e.g., in a fanny pack).
 - ☐ I/we request our child carry their emergency rescue medication while at school.
 - ☐ When student is off site at HCDSB/school sponsored activities/events the medication will be:
 - Carried by the student ☐ Yes ☐ No
 - OR
 - Carried by the trained staff ☐ Yes ☐ No
 - ☐ We will inform the school of any change in medication or delivery device. The medication **cannot** be beyond the expiration date.

Parent/Guardian Name: _____
(Please print) (Signature)

Date: _____

Student Name: _____
(18 yrs. or older) (Please print) (Signature)

Date: _____

AUTHORIZATION/CONSENT

The following will be shared with appropriate school staff and others, and/or posted:

- Student Plan of Care – on file in Office and Classroom Teacher
- Identification and Emergency Treatment Plan – posted in classroom
- Identification and Emergency Treatment Plan (HSTS) – shared with Halton Student Transportation Services (if applicable)
- At-a-Glance – posted in Staff Room(s); Health Room; First Aid Room; Office (as applicable)

Parents/Guardians: _____ Date: _____
Signature

Student: _____ Date: _____
(18 yrs. or older) Signature

Principal: _____ Date: _____
Signature

PLAN REVIEW

This plan remains in effect for the school year and will be reviewed annually.

Please Note:

1. It is the parents/guardians' responsibility to notify the principal if there is a need to change the plan of care during the school year.

2. Where there has been no change in the child's condition or treatment strategy from the previous year, parents/guardians may authorize continuation of the Diabetes identification, information or Emergency Treatment Plan without proof of diagnosis with initials below.

There has been no change in condition or treatment strategy or medication from previous year:

Parent(s)/Guardian(s) initial(s): _____ Year: _____ Year: _____ Year: _____

This information is collected pursuant to s. 170 and s.265(1)i) of the *Education Act*, R.S.O. 1990, c. E-2 and s.28(2), 29, 30, 31, 32 and 33 of the *Municipal Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. M-56 and the *Personal Health Information Protection Act*, 2004, S.O. 2004, c.3, Sch. A. If you have any questions regarding your child's personal information, please contact the Principal of your child's

Signed Original (Student Plan of Care + Request and Consent for the Administration of Diabetes Intervention Medication(s)): Filed in School Office

Student Plan of Care: Copy to Teacher file Student Plan of Care: Copy to Secondary Occasional Teacher file; [Identification and Emergency Treatment Plan: Posted in Classroom]

REQUEST AND CONSENT FOR THE ADMINISTRATION OF DIABETES INTERVENTION(S)/MEDICATION(S)

This form is completed when the school agrees with the parental request to administer Diabetes intervention(s)/medication(s) and reflects the contents of the Student Plan of Care and the HCDSB Diabetes Protocol. **A new form is required:** a) at the initiation of this process; b) at the beginning of each school year; c) when intervention/medication changes. Staff agreeing to administer Diabetes intervention(s)/medication(s) will do so according to the information in the Student Plan of Care.

Student Name:	Date:
Teacher:	Grade:

STATEMENT OF UNDERSTANDING

Regarding parent/guardian requests to provide Diabetes intervention(s)/medication(s) to students by Employees of the Halton Catholic District School Board.

As the parents/guardians of _____, I/we accept and endorse the following terms and/or
(Print name of student)

conditions pertaining to my (our) request for Halton Catholic District School Board employees to provide, under our own authority, my (our) child with interventions listed on the Diabetes Student Plan of Care. Specifically,

I/we understand and accept that:

1. I/we are responsible for supplying and maintaining a limited but adequate supply of fast-acting sugar (e.g., juice boxes);
2. I/we are responsible for supplying our child's/the student's blood sugar testing items and insulin injection supplies, and I/we agree that such supplies are to be in a safe container, labeled with our child's name for transport and storage in class.
3. If applicable, I/we are responsible for supplying our child's/the student's emergency rescue medication (i.e., glucagon intranasal spray).
4. I/we are responsible for providing up to date information to the school regarding changes in the medical condition, as well as changes that may affect the treatment as outlined in the Diabetes Student Plan of Care.
5. I/we understand that HCDSB employees do not: administer insulin syringe injections; push the release button on the insulin pump (bolus); store insulin overnight; determine procedures for low blood glucose count; supply fast-acting sugar; administer glucagon syringe injections; dispose of sharp objects.
6. I/we understand that HCDSB employees are not trained health professionals and, hence, may not recognize the symptoms of my (our) child's medical condition or know how to treat the medical condition;

REQUEST AND CONSENT FOR THE ADMINISTRATION OF DIABETES INTERVENTION(S)/MEDICATION(S)

Insofar as it concerns my child _____, I/We:

- I. agree to comply with the responsibilities described above;
- II. request that the intervention(s)/medication(s) listed in the Diabetes Student Plan of Care be administered to my/our child according to the information we have provided; and furthermore,
- III. acknowledge that I/we are aware and understand my/our child's medical condition and the risks associated with its care and emergency treatment, that the Halton Catholic District School Board and its staff and volunteers are acting in their role as educators and not health professionals, and that there is a risk of loss, damage, and injury to my child, including death, or to my property in the possession of my child, as a consequence of administering the interventions/medications, failing to administer the interventions/medications or failing to correctly administer the interventions/medications identified.

Having read and understood the information conveyed in the "Statement of Understanding" and the "Request and Consent for the Administration of Diabetes Intervention(s)/Medication(s)" form, I/we agree to comply with the responsibilities described above.

Signature of Parent/Guardian: _____

Date: _____

Signature of Student: _____

Date: _____

(18 years of age or older)