To be completed by a Licensed Healthcare Provider

Care Plan for Student with Diabetes			
Name:	DOB:	Valid Current School Year:	Type 1 □
School:	Grade:	Year Diagnosed:	Type 2 □

Parent/ Legal Guardian's Contact Information	
Name:	Contact Number:
Name:	Contact Number:

Trained Diabetes Care Team Members

School Nurse Signature:	
***Parent/Legal Guardian Signature:**	

*Parent/ Legal Guardian: By signing, I understand that all procedures will be implemented in accordance with state laws and regulations and may be performed by an unlicensed school personnel under the training and supervision provided by the school nurse.