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# Health Services

# Dexcom Authorization Letter

Date: _____

I, _____, request that the school nurse monitor my child's, _____, blood glucose during the school day via the share application on a device located within the clinic.

__ I agree to prepare an electronic invitation to the school nurse via the device application and send it via email to the email address provided by my child's school nurse. No personal emails or texts shall be used in this function.

__ I understand that the availability of this monitoring service is subject to the availability and functionality of a Wi-Fi signal and may not be in service at all times.

__ I understand that while the monitoring device will be located in the clinic, there is no guarantee that the school nurse will be watching the device at all times throughout the school day.

__ I understand that this service is strictly a convenience and extra level of care, not a replacement for check-ins with the school nurse, face-to-face assessment and/or nurse-monitored diabetic care.

If you have any questions or concerns about your child's monitoring or treatment, please contact the school nurse.

_____ _____

Parent\guardian signature: Date:

_____ _____

School nurse signature: Date: