ACCOMMODATIONS REQUEST: BLOOD GLUCOSE AND DIABETES MANAGEMENT PLAN

Child's Name: _____ School Number: _____

Director/Principal Name: _____ School Phone: _____

Is this request for a child currently enrolled or prospective enrollment?

☐ Currently Enrolled, Enrollment Date: _____

☐ Prospective Enrollment, Desired Enrollment Date: _____

Accommodations Request Process

1. Review the included Policy for Blood Glucose and Diabetes Management with the parent/guardian.
2. Ensure the Authorization for Blood Glucose and Diabetes Management Plan is completed.
    a. Part I: Completed by Physician
    b. Part II: Completed by the Parent/Guardian
3. Ensure the Release and Waiver of Liability for Children with Blood Glucose and Diabetes Management is completed and signed by the Director/Principal and the Parent/Guardian(s).
4. Ensure all employees that have been trained to provide blood glucose and diabetes management to the child have completed and signed the Blood Glucose and Diabetes Management Training Acknowledgment.
5. Ensure the parent/guardian(s) have signed the Acknowledgment of Receipt of Policy for Blood Glucose and Diabetes Management form.

Submitting the Accommodation Request (Director/Principal):

Collect the following completed forms and any other pertinent information provided by the parent/guardian or physician:

☐ Accommodations Request Cover Sheet (this form)

☐ Authorization for Blood Glucose and Diabetes Management Plan

☐ Release and Waiver of Liability for Children with Blood Glucose and Diabetes Management

☐ Blood Glucose and Diabetes Management Training Acknowledgment

☐ Acknowledgment of Receipt of Policy for Blood Glucose and Diabetes Management Form

**Please do not include the Policy for Blood Glucose and Diabetes Management in the final request that is sent to the Inclusion Team for approval.*

Scan the completed documents* and submit to the Inclusion Team via LCGNow.
If you have any questions, email the Inclusion Team:
InclusionTeam@LearningCareGroup.com

POLICY FOR BLOOD GLUCOSE AND DIABETES MANAGEMENT

Children with insulin-dependent diabetes generally require a diabetes management plan that may include blood glucose testing 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:

- A signed copy of Childtime'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 Learning Care Group, Inc. and it's affiliates and subsidiaries (the Company) with the information necessary to ensure its effective care of children withinsulin-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 Company care of the child's diabetes, if any.
- A signed copy of the Company's "Release and Waiver of Liability for Children with Insulin- Dependent Diabetes" (Waiver). The waiver releases the Company 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 Company 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 file and sending them to the Inclusion Team
- 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 Company 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 management; or
4. The Company employees 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 number 4 is selected, Company employees 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 theappropriate 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 Company employees 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 the child's Teacher(s), with respect to the child's Blood Glucose and Diabetes Medical Management Plan.

    a. 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 levels (by calculating insulin dosage and administering insulin), proper sharps 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 for in the Authorization form.

2. At least four (4) members of the Company's 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 Company's 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 Management 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.

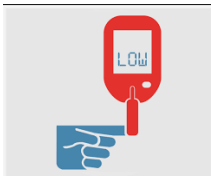
The blood glucose level (number) will be entered on a log provided by the parent(s)/guardian(s) and the appropriate actions will be taken as set out in the Blood Glucose and Diabetes Management Plan. If the blood glucose level (number) falls outside the target range specified in the plan, the appropriate actions will be taken and then the parent(s)/guardian(s) will be called and advised of the blood glucose number and actions taken.

a. ***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.

b. 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.

6. 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.

7. 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
- Nervous/Anxious
- Increased Sweating
- Blurred Vision
- Increased Hunger
- Fatigue/Weakness
- Confusion/Loss of Consciousness
- Sleepiness
- Changed Behavior
- Paleness
- Dilated Pupils
- Increased Heart-Rate or Palpitations
- Yawning
- Irritability/Frustration
- Inability to Swallow
- Sudden Crying
- Restlessness
- Dazed Appearance
- Seizures

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, etc.

HYPERGLYCEMIA (HIGH BLOOD SUGAR)

Signs and Symptoms:

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

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 with the Company so we may assist with the blood glucose and diabetes management 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.

PART I: BLOOD GLUCOSE AND DIABETES MANAGEMENT PLAN (to be completed by the physician)

Child's Name:_____ 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 [ ] Before Lunch [ ] Before physical activity [ ]____ hours after breakfast

[ ] After Breakfast [ ] After Lunch [ ] After physical activity [ ]____hours after lunch

[ ] Mid-Morning [ ] 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 for testing: [ ] Side of Fingertip [ ] Other:_____

* Note: the side of the fingertip should always be used to check blood glucose level if 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

[ ] Yes [ ] No 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.

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
   _____ saltine crackers
   _____ pieces of bread or toast
   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, Company staff will notify the child's parent(s)/guardian(s). If the child experiences more serious symptoms (such as loss of consciousness or seizure), Company staff will:

   - Position the student on his or her side to prevent choking.
   - Give glucagon: [ ] 1mg [ ] ½ mg [ ] Other dose: _____
   - Route: [ ] Subcutaneous (SC) [ ] Intramuscular (IM)
   - Site for glucagon injection: [ ] Buttocks [ ] Arm [ ] Thigh [ ] Other: _____
   - Call 911 Emergency Medical Services and the student's parent(s)/guardian(s)

ACTIONS FOR HYPERGLYCEMIA (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 does of insulin (see correction does orders).
4. Notify parent(s)/guardian(s) 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):_____oz 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:

- Breakfast: 1 unit of insulin per_____grams of carbohydrate
- Lunch: 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: _____

Parent(s)/Guardian(s) Authorization to Adjust Insulin Dose

[ ] Yes [ ] No Parent(s)/guardian(s) authorization should be obtained before administering a correction dose.

[ ] Yes [ ] No Parent(s)/guardian(s) are authorized to increase or decrease correction scale within the following range: +/-_____units of insulin.

[ ] Yes [ ] No Parent(s)/guardian(s) 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 Parent(s)/guardian(s) are authorized to increase or decrease fixed insulin dose within the following range: +/-_____units of insulin.

Additional Information for Participant with Insulin Pump

Brand/Model of Pump:_____ Type of Insulin Pump:_____

Basal rates during school:

Time:_____ Basal Rate:_____ Time:_____ Basal Rate: _____ Time:_____ Basal Rate:_____ 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 parent(s)/guardian(s).

[ ] 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 activities: [ ] Yes, for_____hours [ ] No

Set a temporary basal rate: [ ] Yes,_____% temporary basal rate for_____hours [ ] No

Suspend pump use: [ ] Yes, for_____hours [ ] No

Student's Self-Care Pump Skills

[ ] Yes [ ] No 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

Meal Plan

Meal/Snack	Time	Carbohydrate Content_____ to_____ grams
Breakfast		
Mid-Morning Snack		
Lunch		
Mid-Afternoon Snack		

Recreational Activities

[ ] Yes [ ] No The child may participate in recreational activities

Activity Restrictions: [ ] None [ ] Some Restrictions

Explanation:

_____

_____

Diet Restrictions

Parent(s)/guardian(s) are responsible for reviewing the school's menu plan each week and supplying any food substitutions required for their child. The Company 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.

Parent(s)/guardian(s) are responsible for supplying the carbohydrate snacks which need to be given in the event of low blood sugar levels.

Child's Physician

Name:_____ Date:_____

Address:_____

Telephone #:_____ Emergency Contact #:_____

Signature: _____

PART TWO: AUTHORIZATION TO CONDUCT BLOOD GLUCOSE AND DIABETES MANAGEMENT (to be completed by the parent/guardian)

Parent(s)/Guardian(s)

Name: _____

Address: _____

Telephone Number: _____ Emergency Contact Number: _____

Name: _____

Address: _____

Telephone Number: _____ Emergency Contact Number: _____

Indicate the person(s) who is/are authorized to conduct blood glucose and diabetes management.
Check all that apply:
[ ] Company Personnel [ ] Parent(s) or Guardian(s) [ ] Child [ ] Other: _____

By signing this form, I/We authorize Learning Care Group, Inc. and it's affiliates and subsidiaries 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: _____ Date: _____

Signature: _____ Date: _____

RELEASE AND WAIVER OF LIABILITY FOR CHILDREN WITH BLOOD GLUCOSE AND DIABETES MANAGEMENT

This is a release and waiver of liability for children with blood glucose and diabetes management (hereinafter, referred to as the "Release") made this _____ day of, 20____, by and between Learning Care Group, Inc. and it's affiliates and subsidiaries ("Company") and _____

(parent(s)/guardian(s))

residing at _____, (address)

who are the parent(s)/guardian(s) of _____; (child's name)

WHEREAS, the Company provides child care services at numerous facilitates across the country and the parent(s)/guardian(s) has engaged the Company to provide child care for _____ (child's name)

WHEREAS, the Company has been requested by the parent(s)/guardian(s) to provide blood glucose and diabetes management 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 Company'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 Company and it's employees or agents from any and all liability arising in law or equity as a result of the Company'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 Company 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 Company's facility in which the child is enrolled, excluding its choice of law Provisions.
3. The 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 Company 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. In 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.

Learning Care Group, Inc.

By: _____

Name: _____

Title: _____

Date: _____

Parent(s) or Guardian(s)

By: _____

Name: _____

Relationship: _____

Date: _____

By: _____

Name: _____

Relationship: _____

Date: _____

BLOOD GLUCOSE AND DIABETES MANAGEMENT TRAINING ACKNOWLEDGMENT

At least four (4) members** of the school staff, including but not limited to, the **Director, Assistant Director, and child's teacher(s)**, shall attend the training provided by the qualified health care provider or diabetes educator. **All 4 trained employees must complete the information below.

I, ____(staff member), have been trained by

____(physician, physician's assistant, Certified Diabetes Educator, or nurse) to provide blood glucose and diabetes management to ____________________________________(child's name) an insulin-dependent diabetic child enrolled with Learning Care Group, Inc.

Employee Signature: ____ Date of Training: ________________

I, ____(staff member), have been trained by

____(physician, physician's assistant, Certified Diabetes Educator, or nurse) to provide blood glucose and diabetes management to ____________________________________(child's name) an insulin-dependent diabetic child enrolled with Learning Care Group, Inc.

Employee Signature: ____ Date of Training: ________________

I, ____(staff member), have been trained by

____(physician, physician's assistant, Certified Diabetes Educator, or nurse) to provide blood glucose and diabetes management to ____________________________________(child's name) an insulin-dependent diabetic child enrolled with Learning Care Group, Inc.

Employee Signature: ____ Date of Training: ________________

I, ____(staff member), have been trained by

____(physician, physician's assistant, Certified Diabetes Educator, or nurse) to provide blood glucose and diabetes management to ____________________________________(child's name) an insulin-dependent diabetic child enrolled with Learning Care Group, Inc.

Employee Signature: ____ Date of Training: ________________

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

ACKNOWLEDGMENT OF RECEIPT OF POLICY FOR GLUCOSE AND DIABETES MANAGEMENT

I acknowledge that I have received a copy of Learning Care Group, Inc.'s Policy for Blood Glucose and Diabetes Management.

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

Date: _____