Continuous Glucose Monitoring Parent/Guardian Agreement and Acknowledgment Form

I am the Parent/Guardian of ______________________________________ ("child") and I hereby grant permission to school personnel of the Keller Independent School District ("KISD" or "District") to access the continuous glucose monitor via the corresponding App ("CGM App") of my child. In order for school personnel of the KISD to access the CGM App of my child, I hereby understand, acknowledge and agree to the following:

1. Neither law nor policy requires the KISD to access or monitor my child's CGM App or continuously monitor my child's glucose in any manner.
2. I hereby grant KISD school personnel any and all access to my child's CGM App.
3. KISD school personnel will not continuously monitor my child's glucose via his/her CGM App.
4. KISD school personnel will monitor and treat my child for medical reasons, including, but not limited to, monitoring and treatment for diabetes, as they do all students.
5. Should KISD school personnel elect to access my child's CGM App, they shall do so via the platform selected by the District on a District-owned device and only during school hours or while at a school sponsored activity.
6. CGM-based treatment decisions may be made using only a device that is FDA-approved for treatment as indicated on the child's diabetes medical management plan. I understand that school personnel will check a finger stick blood glucose to confirm the glucose level in situations where they are not confident of CGM App readings. The physician's orders, daily treatment plan and the nurse's assessment will continue to be the primary methods for providing care to my child.
7. I understand that medications containing acetaminophen (Tylenol) can give false high CGM App readings and it is my responsibility to notify school personnel when my child has received acetaminophen (Tylenol).
8. I understand that my child's CGM App requires wireless internet service and that the KISD is not responsible for any lapse in wireless internet service or any wireless "connection" issues of any kind.
9. I understand that I am solely responsible for the maintenance and upkeep of my child's CGM, including, but not limited to, ensuring proper functioning of the CGM and that any and all software and/or program updates have been completed, and that the KISD is not responsible for any functioning issues that may occur with my child's CGM and will not use CGM readings for treatment if the device is not FDA approved and properly maintained and calibrated.
10. I understand that I am solely responsible for calibrating my child's CGM according to manufacturer's guidelines.
11. I understand that my child's CGM App health information shall be displayed on a screen that a person other than KISD school personnel may view or have access to and I therefore waive and release the KISD from any and all claims under the Health Insurance Portability and Accountability Act (HIPAA) and Family Education Rights and Privacy Act (FERPA).
12. KISD is not responsible for any lost or stolen CGM equipment.
13. **Students whose diabetic orders indicate they are independent in the treatment of their diabetes will not be monitored by district employees via CGM App. Trained Staff will assist my child in emergency situations, and as indicated in diabetes management plan.**

____ I hereby certify that my child is independent per the physician's diabetes management plan.
____ I hereby certify that my child requires assistance per the physician's diabetes management plan to respond to or access his/her CGM.

By execution of this document, I acknowledge and agree to the above and hold harmless the Keller ISD, its employees, agents, representatives, and board of trustees, from and against any and all claims, causes of action, damages, losses, and expenses, including attorney's fees, arising out of or resulting from the District's use, or my child's use, of my child's CGM App.

___________________________________ ___________________________________
Signature of Parent/Legal Guardian Signature of Child

___________________________________ ___________________________________
Printed Name of Parent/Legal Guardian Printed Name of Child

___________________________________ ___________________________________
Date Date

Signature of School Nurse: ____ Date: ________________________