Treatment

Will any visiting/consulting nurses be supporting this child/student? ☐ **Yes** ☐ **No**

(If yes, please provide details)

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Additional information attached to this care plan

- ☐ *General information about this child's/student's condition*
- ☐ *Additional individual care information*
- ☐ *Other (please specify)*

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AUTHORISATION AND RELEASE

Diabetes specialist ..... Professional role .....

Name of agency/address .....

..... Telephone .....

Signature ..... Date .....

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to education/childcare staff and emergency medical personnel.

Parent/guardian
or adult student ..... Signature ..... Date .....
Family name (please print) First name (please print)