Salem City Schools Continuous Glucose Monitoring Agreement

School Year 20__ - 20__

Date: _____

I, _____, request that the school nurse and SCS personnel to monitor my child's, _____, blood glucose during the school day via a CGM share (i.e. Dexcom) on a device located within the school health office. ____ In the event a school provided device (tablet) is available, I agree to prepare an electronic invitation to the school nurse via the CGM (i.e. Dexcom) share application and send it via email to the email provided by my child's school nurse. No personal email or text shall be used when setting up this process.

_____ I understand and agree that the provider's orders in my child's Diabetes Medical Management Plan (DMMP) and the nurse's assessment will be the primary methods for providing care to my child.

_____ I acknowledge that my child is aware of the medical device's alarms, if applicable, and understands to notify their teacher, school nurse, or other SCS personnel when an alarm sounds. □ Yes □ No

____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 health office, 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 for face-to -face assessment.

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

_____ _____

Parent / Guardian Signature Date

_____ _____ School Nurse

Signature Date AH/Sept. 2025