



FM 5336 F2

**Westerville City Schools  
Addendum for Diabetes Care  
(Attach this page to Medical Providers Order)**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Diabetes Type: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_

School Name: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_

**Signatures**

I, (parent/guardian) \_\_\_\_\_ give permission to the school nurse or another qualified health care professional or trained diabetes personnel to perform and carry out the diabetes care tasks as outlined in this Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to collaborate with my student's physician/health care provider.

**Acknowledged and received by:**

Student's Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse or Designee: \_\_\_\_\_ Date: \_\_\_\_\_

2/24/25