

Saint Thomas Acadmey

Blood Glucose Consent Form

Student: _____ Room: _____ Grade: _____ Age: _____

Family Physician: _____

Address _____ Phone: _____

I give my consent for _____ to do blood glucose monitoring at school
Student

Parent/Guardian Signature

I would like the testing records sent home _____ and wish to be
Weekly/Biweekly
notified under the following circumstances:

e.g.

A) Severe low blood glucose reaction not responding to treatment within 1/2 hour.

B) Blood glucose levels above 300 for 3 days in a row.

C) Blood glucose greater than 240.

D) Other circumstances as described.

