Accommodations Request:
Blood Glucose and Diabetes Management Plan

Child’s Name: ________________________________
School Number: ________________________________
Director Name: ________________________________
School Phone #: ________________________________

☐ Prospective Enrollment

Date parent/guardian would like child to begin: ________________________________

☐ Child Currently Enrolled

Date child began enrollment: ________________________________

Please include the following completed information along with this coversheet:

☐ Blood Glucose and Diabetes Management Plan
☐ Any other pertinent information provided by parent/guardian

Completed packets should be returned to the school by the parents and submitted by the school to the inclusion team.

Please email the entire packet, using this page as your cover, to the Inclusion Team:
inclusionteam@learningcaregroup.com

If you must fax, send to 248-675-4940

Call Leah Riker at 248-675-0408 for questions.
POLICY FOR BLOOD GLUCOSE AND DIABETES MANAGEMENT

Children with insulin-dependent diabetes generally require a diabetes management plan that may include blood glucose testings and other accommodations. Accordingly, when an enrolling/enrolled child has insulin-dependent diabetes, the following is required:

PARENT(S)/GUARDIAN(S) MUST COMPLETE AND/OR PROVIDE THE FOLLOWING:

1. A signed copy of Childtime’s "Authorization for Blood Glucose and Diabetes Management Plan" (Authorization Form). This form must be filled out completely by the child's physician and parent(s)/guardian(s) and must be updated approximately every six months, or more frequently, as needed. The Authorization Form is designed to provide Childtime with the information necessary to ensure its effective care of children with insulin-dependent diabetes. In addition, the parent(s)/guardian(s) shall provide a copy of any other health care professional's orders and procedural guidelines relating to Childtime's care of the child's diabetes, if any.

2. A signed copy of Childtime's "Release and Waiver of Liability for Children with Insulin-Dependent Diabetes" (Waiver). The Waiver releases Childtime and its employees from liability for administering care pursuant to the diabetes management plan and taking any other necessary actions set forth in the Authorization Form, provided that Childtime exercises reasonable care in taking such actions.

*Note: The Managing Director is responsible for: (1) collecting these documents after they have been properly executed and (2) placing a copy of each form in the child's Childtime file and sending them to the inclusion team.

3. All supplemental foods, supplies, and equipment necessary for the diabetes management, including a log book in which to record the test results and a sharps container. The parent(s)/guardian(s) are responsible for the maintenance of materials and equipment, including ensuring that the blood glucose meter is in good working order. Childtime is not responsible for any damage or loss of equipment provided reasonable care is exercised in storing and using these items.

PARENT(S)/GUARDIAN(S) MUST SELECT ONE OR MORE OF THE FOLLOWING FOUR OPTIONS FOR BLOOD GLUCOSE AND DIABETES MANAGEMENT:

1. The child may, with the supervision of a trained school employee, test him/herself, if old enough and authorized by the parent(s)/guardian(s) on the Authorization for Blood Glucose and Diabetes Management Plan (the "Authorization Form");

2. The parent(s)/guardian(s) may come to the Center to perform blood glucose and diabetes management;

3. The parent(s)/guardian(s) may arrange for a third party to come to the Center and perform blood glucose and diabetes management; or

4. Childtime Staff will perform the blood glucose and diabetes management care and take those steps needed to regulate the child's blood glucose as authorized by the parent(s)/guardian(s) on the Authorization Form.

If any option other than No. 4 is selected, Childtime Staff will provide collateral assistance to the child, the parent(s)/guardian(s) or the third party as needed (e.g. in recording the test results, the disposal of sharps, etc).

All necessary members of the staff will be trained to recognize symptoms of high or low blood sugar and to take the appropriate steps for treating the child, as set forth in the authorization form.
PROCEDURES FOR BLOOD GLUCOSE AND DIABETES MANAGEMENT:

If the parent(s)/guardian(s) elect to have Childtime Staff perform the Blood Glucose and Diabetes Management, the following steps must be implemented.

1. Prior to the child's first day of attendance, the parent(s)/guardian(s)/designee(s) is responsible for working jointly with the school to arrange training for selected members of the Staff including, but not limited to, the Director, Assistant Director, and Child's Teacher(s), with respect to the child's Blood Glucose and Diabetes Medical Management Plan. The training should be conducted by a qualified health care provider or diabetes educator, and include hands on training for blood glucose testing, and, where relevant, managing insulin levels (by calculating insulin dosage and administering insulin), proper sharp disposal, as well as taking other appropriate measures, as set forth in the Authorization form. In addition, necessary members of the Staff will be trained to recognize symptoms of high or low blood sugar and to take the appropriate steps for treating the child, as set forth in the Authorization Form.

2. At least four (4) members of Childtime Staff including, but not limited to, the Director, Assistant Director, and Child's Teacher(s), shall attend the training provided by a physician, physician's assistant, or nurse. Upon completion of the training, the Staff shall complete and sign the Blood Glucose and Diabetes Management Training Acknowledgment.

3. Training shall be repeated every six months, or when fifty percent (50%) of Childtime Staff has turned over, whichever occurs first. If the individual serving as the Director, the Assistant Director, and/or the child's teacher(s) is replaced, his or her replacement shall immediately be trained by the parent(s)/guardian(s)/designee(s).

4. At least one (1) Staff member trained to perform the Blood Glucose and Diabetes Management shall be present at all times the child is present at the Center and shall accompany the child on all field trips.

5. Testing equipment and used sharps shall be stored in a secure area accessible only by trained Staff. During Center field trips a trained member of the Staff shall be designated to carry any required testing equipment, food, and sharps disposal containers.

6. Warning signs alerting Staff of the child's diabetes and dietary restrictions shall be posted in the kitchen, the child's classroom, and may be listed on other school documentation.

STEPS FOR PERFORMING BLOOD GLUCOSE AND DIABETES MANAGEMENT AND PROVIDING APPROPRIATE FOLLOW-UP CARE:

Blood glucose monitoring and other diabetes management will be performed as specified in the child's individualized Blood Glucose and Diabetes Management Plan. Signs and symptoms of hyperglycemia and hypoglycemia are listed on the attached chart. In addition, each Center will be provided with a chart containing this information to be posted for Staff awareness. Generally, the following steps will be followed, unless other instructions are provided in the child's Blood Glucose and Diabetes Management Plan.

1. The designated Staff member(s) will collect all necessary equipment/supplies.

2. Staff will ensure that the child washes his/her hands with soap and water.
3. The Staff member will wash his/her hands with soap and water and apply gloves, in accordance with OSHA requirements.

4. The child's finger will be shallowly pricked with the supplied sharps device, using caution to prick the sides of the finger. Staff will use a different finger each day for the testing unless otherwise indicated on the child's individualized Blood Glucose and Diabetes Management Plan.

5. When the blood glucose test is completed, the child's finger will be covered with an adhesive bandage, and the meter and sharps device returned to the designated container. When the parent(s)/guardian(s) is notified that the sharps container is full, the parent(s)/guardian(s) will remove the container and dispose of any used sharps in the appropriate manner. Under no circumstance are sharps to be disposed of at the Center.

6. The blood glucose level (number) will be entered on a log provided by the parent(s)/guardian(s) and the appropriate actions will be taken as set out in the Blood Glucose and Diabetes Management Plan. If the blood glucose level (number) falls outside the target range specified in the plan, the appropriate actions will be taken and then the parent(s)/guardian(s) will be called and advised of the blood glucose number and actions taken. [Note: Parent(s)/guardian(s) are responsible for providing a contact number where they can be reached when necessary.] In the interim, if the child becomes lethargic, dizzy, or feels faint, call the area's emergency personnel number (e.g."911") and the child's doctor's office. In the event of any conflict between this policy document and the instructions set forth in the Blood Glucose and Diabetes Management Plan, the instructions in the plan must be followed.

7. Insulin dose will be calculated and insulin administered in accordance with the Blood Glucose and Diabetes Management Plan, and policies on first aid and medication.

8. For insulin delivery via pump or pen, parent(s)/guardian(s) shall provide the Center with manufacturer information to ensure proper use.
HYPOGLYCEMIA
(LOW BLOOD SUGAR)

Signs and Symptoms:

<table>
<thead>
<tr>
<th>Shaking</th>
<th>Sleepiness</th>
<th>Extreme tiredness/fatigue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nervous/anxious</td>
<td>Changed Behavior</td>
<td>Inability to Swallow</td>
</tr>
<tr>
<td>Increased Sweating</td>
<td>Paleness</td>
<td>Sudden Crying</td>
</tr>
<tr>
<td>Blurred Vision</td>
<td>Dilated Pupils</td>
<td>Restlessness</td>
</tr>
<tr>
<td>Increased Hunger</td>
<td>Increased Heart-Rate or Palpitations</td>
<td>Dazed Appearance</td>
</tr>
<tr>
<td>Fatigue/Weakness</td>
<td>Yawning</td>
<td>Seizures</td>
</tr>
<tr>
<td>Confusion/Loss of Consciousness</td>
<td>Irritability/Frustration</td>
<td></td>
</tr>
</tbody>
</table>

Causes: skipping meals, too much insulin, too much exercise

Treatment: Have child eat or drink something that is high in sugar content, i.e., apple juice, orange juice, carbonated beverage, milk.

HYPERGLYCEMIA (HIGH BLOOD SUGAR)

Signs and Symptoms:

<table>
<thead>
<tr>
<th>Increased Thirst</th>
<th>Lack of Concentration</th>
<th>Weight loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased Hunger</td>
<td>Profound Weakness</td>
<td>Stomach Pains</td>
</tr>
<tr>
<td>Increased Urination</td>
<td>Confusion</td>
<td>Flushing of Skin</td>
</tr>
<tr>
<td>Blurred Vision</td>
<td>Dry Mouth</td>
<td>Fatigue/Sleepiness</td>
</tr>
<tr>
<td>“Fruity” Smell to Breath</td>
<td>Stomach Cramps</td>
<td>Vomiting</td>
</tr>
<tr>
<td>Nausea</td>
<td>Loss of Consciousness</td>
<td>Labored Breathing</td>
</tr>
</tbody>
</table>

Causes: skipping insulin, too much food

Treatment: Because the child may need an insulin injection, contact the parents or the child's physician immediately.
AUTHORIZATION FOR BLOOD GLUCOSE AND DIABETES MANAGEMENT PLAN

Dear Doctor ________________________________ Date ____________________

Your patient, __________________________________, is enrolled/enrolling in our Center and we have been requested to provide blood glucose and diabetes management and appropriate follow-up care. Please complete Part I of this instruction record. This record will remain in the child's file at Childtime so we may assist with the blood glucose and diabetes management and other needs of our enrollee and your patient. If you need to provide further instructions or clarifications, please do so on a separate sheet of paper, which will become a part of this record and will be kept with this form in the child's file at Childtime.

PART I BLOOD GLUCOSE AND DIABETES MANAGEMENT PLAN (to be completed by physician)

Child’s Name: ________________________________ Child’s Birth Date: ____________________

Date of diabetes diagnosis: ____________________

Target range of blood glucose: [ ] 70-180 [ ] 180-240 [ ] other ______- _______

Name of blood glucose meter child is using: ________________________________

PROCEDURES

Blood glucose and diabetes management is performed before lunch and, in addition, at any time the child exhibits signs and symptoms of hyperglycemia or hypoglycemia, as described on the attached form. Parent(s)/guardian(s) must supply blood glucose monitoring materials (meter and strips or chemstrips, lancet, adhesive bandages, etc.).

Other materials shall include (give detail) ________________________________

Parent(s)/guardian(s) are responsible for providing an appropriate container for the disposal of any "sharps" items. When the parent(s)/guardian(s) is notified that the sharps container is full, the parent(s)/guardian(s) will remove the container and dispose of any used sharps in the appropriate manner.

CHECKING BLOOD GLUCOSE

Brand/model of blood glucose meter: ________________________________ Target range of blood glucose:

Before meals: [ ] 90–130 mg/dL [ ] Other: __________

Check blood glucose level:
[ ] Before breakfast [ ] After breakfast [ ] ___ hours after breakfast
[ ] Before lunch [ ] After lunch [ ] ___ hours after lunch
[ ] Mid-morning [ ] Before physical activity [ ] After physical activity
[ ] 2 hours after correction dose [ ] other: __________

[ ] As needed for signs/symptoms of low or high blood glucose
[ ] As needed for signs/symptoms of illness

Preferred site of testing: [ ] Side of fingertip [ ] other: __________

Note: The side of the fingertip should always be used to check blood glucose level is hypoglycemia is suspected. Student's self-care blood glucose checking skills:
[ ] Independently checks own blood glucose [ ] May check blood glucose with supervision
[ ] Requires trained personnel to check blood glucose
[ ] Uses smartphone or other monitoring technology to track blood glucose values
Continuous Glucose Monitor (CGM): [ ] Yes [ ] No

Brand/model: ___________________

Alarms set for:
- Severe Low: ________
- Low: ________
- High: ________

Predictive alarm:
- Low: ________
- High: ________

Rate of Change:
- Low: ________
- High: ________

Threshold suspend setting: ______________________________________________________________

Student's Self-Care CGM Skills

Student troubleshoots alarms and malfunctions. [ ] Yes [ ] No

Student knows what to do and is able to deal with a HIGH alarm. [ ] Yes [ ] No

Student knows what to do and is able to deal with a LOW alarm. [ ] Yes [ ] No

Student can calibrate the CGM. [ ] Yes [ ] No

Student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose level. [ ] Yes [ ] No

Other instructions:_____________________________________________________________________

ACTIONS FOR HYPOGLYCEMIA (LOW BLOOD SUGAR) (BELOW _______);

1. Student's usual symptoms of hypoglycemia: ____________________________
   
   If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL, give one of the following fast-acting carbohydrates in the following quantities (please delete those items which are not recommended):
   - ________ oz. apple or orange juice;
   - ________ oz. milk;
   - ________ oz. carbonated beverage with sugar: hard candies.
   Other__________.

2. If lunch or snack is greater than one hour away. ALSO give the child one of the following in these quantities:
   - # graham cracker squares;
   - #_______saltines;
   - # _______pieces of bread or toast;
   - Other: ____________.

3. Recheck blood glucose test in 15 minutes and repeat treatment if blood glucose level is less than ____ mg/dL.

4. If the child experiences the following symptoms, and they are not eliminated by the actions specified above, contact the parent(s)/guardian(s) immediately and ask him or her to come to the Center to take the child to his/her physician:
   (Please indicate the symptoms that require parental notification.)
   - _____Dizziness
   - _____Weakness
   - _____Impaired Vision
   - _____Other: _____________________________________________

5. If the steps outlined above do not eliminate the child's symptoms, Childtime staff will notify the child's parents/guardians.
   
   If child experiences more serious symptoms (such as loss of consciousness or seizure), Childtime Staff will:
   - Position the student on his or her side to prevent choking.
   - Give glucagon:
     - [ ] 1 mg
     - [ ] 1/2 mg
     - [ ] other dose__________
   - Route:
     - [ ] subcutaneous (SC)
     - [ ] intramuscular (IM)
   - Site for glucagon injection:
     - [ ] buttocks
     - [ ] arm
     - [ ] thigh
     - Other__________ - Call 911 Emergency Medical Services and the student's parents/guardians.
ACTIONS FOR HIGH BLOOD SUGAR (ABOVE______);

1. Student’s usual symptoms of hyperglycemia: ____________________________________________

2. Check [ ] urine [ ] blood for keytones every ___ hours when blood glucose levels are above ___ mg/dL.

3. For blood glucose greater than ___ mg/dL AND at least ___ hours since last insulin dose, give correction dose of insulin (see correction dose orders).

4. Notify parents/guardians if blood glucose over ___ mg/dL.

5. Allow unrestricted access to the bathroom.

6. Give extra water and/or non-sugar-containing drinks (not fruit juices): ____ ounces per hour.

INSULIN THERAPY

Insulin delivery device: [ ] syringe [ ] insulin pen [ ] insulin pump

Type of insulin therapy at school: [ ] adjustable (basal-bolus) insulin [ ] fixed insulin therapy [ ] no insulin

Adjustable (Basal-bolus) Insulin Therapy

- Carbohydrate Coverage/Correction Dose: Name of insulin: _____________________

- Carbohydrate Coverage: _____________________

  Insulin-to-carbohydrate ratio: lunch: 1 unit of insulin per ___ grams of carbohydrate

  breakfast: 1 unit of insulin per ___ grams of carbohydrate

  snack: 1 unit of insulin per ___ grams of carbohydrate

Carbohydrate Dose Calculation Example

\[
\frac{\text{Total Grams of Carbohydrate to Be Eaten}}{\text{Insulin-to-Carbohydrate Ratio}} = \text{Units of Insulin}
\]

Correction dose: blood glucose correction factor (insulin sensitivity factor) =

_______ Target blood glucose = ______ mg/dL

Correction Dose Calculation Example

\[
\frac{\text{Current Blood Glucose} - \text{Target Blood Glucose}}{\text{Correction Factor}} = \text{Units of Insulin}
\]

Correction dose scale (use instead of calculation above to determine insulin correction dose):

  Blood glucose ___ to ___, give ____ units  Blood glucose ___ to ___, give ____ units

  Blood glucose ___ to ___, give ____ units  Blood glucose ___ to ___, give ____ units

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When to give insulin:

**Breakfast**
- [ ] Carbohydrate coverage only
- [ ] Carbohydrate coverage plus correction dose when blood glucose is greater than ___ mg/dL and ___ hours since last insulin dose.
- [ ] Other: _________________

**Lunch**
- [ ] Carbohydrate coverage only
- [ ] Carbohydrate coverage plus correction dose when blood glucose is greater than ___ mg/dL and ___ hours since last insulin dose.
- [ ] Other: _________________

**Snack**
- [ ] No coverage for snack
- [ ] Carbohydrate coverage only
- [ ] Carbohydrate coverage plus correction dose when blood glucose is greater than ___ mg/dL and ___ hours since last insulin dose.
- [ ] Correction dose only: For blood glucose greater than ___ mg/dL AND at least ___ hours since last insulin dose.
- [ ] Other: _________________

**Fixed Insulin Therapy:**
- Name of insulin: _________________
- [ ] ___ units of insulin given pre-breakfast daily
- [ ] ___ units of insulin given pre-lunch daily [ ]
- ___ units of insulin given pre-snack daily [ ]
- Other: _________________

**Parents/Guardians Authorization to Adjust Insulin Dose**
- [ ] Yes [ ] No Parents/guardians authorization should be obtained before administering a correction dose.
- [ ] Yes [ ] No Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/- ______ units of insulin.
- [ ] Yes [ ] No Parents/guardians are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: ______ units per prescribed grams of carbohydrate, +/- ______ grams of carbohydrate.
- [ ] Yes [ ] No Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/- ______ units of insulin.

**Participant’s self-care insulin administration skills:**
- Independently calculates and gives own injections [ ] yes [ ] no
- May calculate/give own injections with supervision [ ] yes [ ] no
- Other: _________________

**Additional Information for Participant with Insulin Pump**
1. Brand/Model of pump______________________________
2. Type of insulin in pump__________________________________________
3. Basal rates during school:
   - Time: _____ Basal rate: _____  
   - Time: _____ Basal rate: _____  
   - Time: _____ Basal rate: _____
   - Time: _____ Basal rate: _____  
   - Time: _____ Basal rate: _____  
   - Time: _____ Basal rate: _____  
- Other pump information__________________________________________
Type of infusion set: ____________________________________________________________
Appropriate infusion site(s): __________________________________________________
[ ] For blood glucose greater than ___ mg/dL that has not decreased within ___ hours after correction, consider pump failure or fusion site failure. Notify parents/guardians.
[ ] For infusion site failure: insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.
[ ] For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen.

Physical Activity
May disconnect from pump for sports activities: [ ] yes, for ___ hours [ ] no
Set a temporary basal rate: Suspend pump use: [ ] yes, for ___ hours [ ] no

Student's self-care pump skills
Counts carbohydrates [ ] Yes [ ] No
Calculates correct amount of insulin for carbohydrates consumed [ ] Yes [ ] No
Administers correction bolus [ ] Yes [ ] No
Calculates and sets basal profiles [ ] Yes [ ] No
Calculates and sets temporary basal rate [ ] Yes [ ] No
Changes batteries [ ] Yes [ ] No
Disconnects pump [ ] Yes [ ] No
Reconnects pump to infusion set [ ] Yes [ ] No
Prepares reservoir, pod, and/or tubing [ ] Yes [ ] No
Inserts infusion set [ ] Yes [ ] No
Troubleshoots alarms and malfunctions [ ] Yes [ ] No

Meal Plan
<table>
<thead>
<tr>
<th>Meal/Snack</th>
<th>Time</th>
<th>Carbohydrate Content (Grams)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid-morning snack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid-Afternoon Snack</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Recreational Activities
1. The child may participate in recreational activities. [ ] Yes [ ] No
2. Activity restrictions: [ ] None [ ] Some Restrictions
   (Explain): ________________________________________________________________

Diet Restrictions
1. Parent(s)/guardian(s) are responsible for reviewing Childtime's menu plan each week and supplying any food substitutions required for their child. Childtime is responsible for notifying parent(s)/guardian(s) if a birthday or holiday party or any other special event involving food is planned for that week so that parent(s)/guardian(s) may have the option of providing a snack that meets the child's dietary restrictions.
2. Parent(s)/guardian(s) are responsible for supplying the carbohydrate snacks which need to be given in the event flow blood sugar levels.

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Child's Physician
Name: __________________________________________________________
Address: ________________________________________________________
Telephone No.:___________________________________________________
Emergency Contact No.:____________________________________________
Signature: _______________________________________________________
Date: ___________________________________________________________________
PART II (to be completed by Parent(s)/Guardian(s))

Parent(s)/Guardian(s)

Name: _________________________________________________________
Address: _______________________________________________________
Telephone No.: __________________________________________________
Emergency Contact No.:___________________________________________

Name: _________________________________________________________
Address: _______________________________________________________
Telephone No.: __________________________________________________
Emergency Contact No.:___________________________________________

Indicate the person(s) who is/are authorized to conduct blood glucose and diabetes management. (Check all that apply.)
[ ] Childtime Personnel
[ ] Parent(s) or Guardian(s)
[ ] Child
[ ] Other

Names:
(1) ___________________________________________
(2) ___________________________________________

By signing this form, I/We authorize Childtime to follow the above instructions in the Blood Glucose and Diabetes Management Plan. I/We agree to update this plan every six (6) months, or sooner if my/our child's needs change.

Signature: ___________________________________________
(Parent /Guardian)
Date: ___________________________________________

Signature: ___________________________________________
(Parent /Guardian)
Date: ___________________________________________
RELEASE AND WAIVER OF LIABILITY FOR CHILDREN WITH INSULIN-DEPENDENT DIABETES

THIS IS A RELEASE AND WAIVER OF LIABILITY FOR CHILDREN WITH INSULIN-DEPENDENT DIABETES (hereinafter, referred to as the “Release”)

made this __________ day of, 20______, by and between Childtime Childcare, Inc.

("Childtime")

and __________________________________________

(Parent(s)/Guardian(s))

residing at ________________________________________, who are the Parent(s)/Guardian(s)

(Address)

of __________________________________________

(Child's Name)

WHEREAS, Childtime provides child care services at numerous facilities across the country and the Parent(s)/Guardian(s) has engaged Childtime to provide child care for __________________________

(Child's Name)

WHEREAS, Childtime has been requested by the Parent(s)/Guardian(s) to provide blood glucose and diabetes management to their child at certain times while their child is enrolled in the Center and take certain actions as prescribed in writing on the child’s “Blood Glucose and Diabetes Management Plan,” all in accordance with and subject to Childtime's Policy for Blood Glucose and Diabetes Management.

NOW, THEREFORE, in consideration of the agreements and covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

1. Parent(s)/Guardian(s) hereby releases and forever discharges Childtime and its employees or agents from any and all liability arising in law or equity as a result of Childtime's employees or agents performing with "reasonable care" blood glucose and diabetes management and/or taking actions in conformance with the child's "Authorization for Blood Glucose and Diabetes Management" (hereinafter referred to as "Authorization"), Parent(s)/Guardian(s) also hereby releases and forever discharges Childtime from any loss or damage incurred in the exercise of reasonable care to any material and/or equipment supplied by the Parent(s)/Guardian(s) in connection with the blood glucose and diabetes management.

2. This Release shall be governed by the laws of the State of __________, which is the location of Childtime facility in which the child is enrolled, excluding its choice of law Provisions.

3. This Release supersedes and replaces all prior negotiations and all agreements proposed or otherwise, whether written or oral, concerning all subject matters covered herein. This instrument, along with the Authorization (including any additional physician's instructions or clarifications), which is hereby incorporated by reference, constitutes the entire agreement among the parties with respect to the subject matters discussed herein.

4. The reference in this Release to the term Childtime shall include its affiliates, successors, Directors, officers, employees and representatives. The terms Parent(s)/Guardian(s) shall include the
dependents, heirs, executors, administrators, assigns and successors or each.

5. If one or more of the provisions of this Release shall for any reason be held invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect or impair any other provision of the Release. This Release shall be construed as if such invalid, illegal or unenforceable provisions had not been contained herein.

CHILDTIME CHILDCARE, INC.

By: _________________________________________________________
Name: _______________________________________________________
Title: ________________________________________________________
Date: ________________________________________________________

PARENT(S) OR GUARDIAN(S)

By: _________________________________________________________
Name: _______________________________________________________
Relationship: __________________________________________________
Date: ________________________________________________________
By: _________________________________________________________
Name: _______________________________________________________
Relationship: __________________________________________________
Date: ________________________________________________________
Blood Glucose and Diabetes Managment
Training Acknowledgment

I, ________________________________________________________, have been trained by
________________________________________________________ to provide blood glucose
(Physician, Physician's Assistant, or Nurse)

and diabetes managment to ____________________________________________
(Child's Name)

an insulin-dependent diabetic child enrolled at Childtime.

Signature: _________________________________________________________
(CT Employee)

Date of Training: ___________________________________________________

Signature: _________________________________________________________
(Parent(s)/Guardian(s))
Acknowledgment of Receipt of Policy for Blood Glucose and Diabetes Management

I acknowledge that I have received a copy of Childtime Childcare, Inc.’s Policy for Blood Glucose and Diabetes Management.

Signature: ________________________________________________

Parent(s)/Guardian(s)

Date: ____________________________________________________