Dexcom Authorization Letter

Date

This is to certify that, I ______________________________________ (parent's name), authorize the Quincy Public School Nurse, to have access to the Dexcom application for my child, [   ] on the device that is kept in the nursing office during QPS school day. This device is only for access to follow the Dexcom app and not intended for communication purposes. It is understood that the purpose of this is not intended to replace the individual appointed to manage the student's medical needs. It is understood by the parents that this app isn't HIPPA/FERPA approved. The nurses will be monitoring the Dexcom follow app as an intermittent monitor and will listen for alarms signaling high/low blood sugars. The student will continue to have a medical bag with him/her at all times which includes student's personal phone that is used for having immediate access to the Dexcom app. All parties understand that technology can fail and will follow direction of DMMP in the event that technology isn't working. All parties understand that this authorization may be revoked at any time.

___________________________	________________________________
Mother/Date	Father/Date
____________________________	________________________________
Principal/Date	School Nurse/Date