Office of Special Education & Supports · 125 South Clark Street, Suite 800 · Chicago, Illinois 60603 • Telephone: 773-553-1800

.

DIABETES DELEGATED CARE AIDE AGREEMENT FORM

Student Name	Student ID#	Date of Birth

Home Address (City, State, Zip Code)	Parent/Guardian Name

Parent/Guardian Home Phone #	Emergency # (Work or Phone)

School Name	Student Grade

The above-referenced student has diabetes and a Diabetes Care Plan has been developed. The Chicago Public Schools is identifying (insert name and title) _____

to act as the student's Diabetes Delegated Care Aide.

Does the parent/guardian accept the above named Delegated Care Aide ☐ Yes ☐ No

Parent/Guardian Signature_____ Date_____

Principal /Assistant Principal_____ Date_____

If the parent does not agree to the identified Delegated Care Aide, the student is not authorized to have a Delegated Care Aide in school. In case of emergency, 911 will be called.

Scan the signed form into the student's SSM file and place hard copy into the student's record. Provide parent with a signed copy of this form.

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