

Tier III Training
(Diabetic Delegation)

Required for staff receiving Diabetic Tier I, II & III Training

Must be student specific

For use only when delegating diabetic medication or task

School: _____

Student Name: _____

Instructor(s): _____

Date: _____

Name PLEASE PRINT	Signature	Name of School/System	Job Title/ Position

By signing I confirmed that I have received a copy of the student's individual health care plan. I understand the plan of care, have no question or concerns regarding the plan and I will contact the school nurse at (Phone#) _____ should I have any questions.