Certificate
OF COMPLETION

IN RECOGNITION OF SUCCESSFUL COMPLETION IN:

Standard - CPR / AED

(Adult / Child / Infant)

Automated External Defibrillator (AED)

THIS CERTIFICATE IS PROUDLY PRESENTED TO:

Eric J Mostoller

The above mentioned Student is now certified in the above mentioned course by demonstrating proficiency in the subject by passing the examination in accordance with the Terms & Conditions of National CPR Foundation - Valid for 2 years. Course administered in accordance with the **2020** ECC/ILCOR and AHA® guidelines. ID#:**AB47BA3**

Completion: **March 15, 2023**

Instructor: **Paul J. Scruton**

COURSE PROVIDED BY:

NationalCPRFoundation

Signature:

Diabetes Caregiver
COVID-19 Liability Waiver

_____knowingly and willingly consent to having diabetes caregiver services given in my home and to my family during the COVID-19 pandemic.

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing. I further acknowledge that _____, the diabetes caregiver has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19. I further acknowledge that the diabetes caregiver cannot guarantee that I will not become infected with the Coronavirus/COVID-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, diabetes caregivers, and other customers receiving diabetes caregiver services and their families. I voluntarily seek services provided by _____, the diabetes caregiver and acknowledge that I am increasing my risk to exposure to the Coronavirus/ COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

I attest that the I and the residents within my home:

- We are not experiencing any symptom of illness such as cough, shorten of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell
- We have not traveled internationally within the last 14 days
- We have not traveled to a highly impacted area within the United States of America in the last 14 days.
- We do not believe any of us have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
- We have not been diagnosed with Coronavirus/COVID-19 and not yet cleared as non-contagious by state or local public health authorities.
- We are following all CDC recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.

I hereby release and agree to hold _____, harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the diabetes caregiver, or that may otherwise arise in any way in connection with any services received from _____. I understand that this release discharges _____ from any liability or claim that I, my heirs, or any personal representatives may have against the diabetes caregiver services offered with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from _____.

Signature_____ Date_____

Individualized Care Plan (TYPE 1)

Date: _____
Client: _____
Client Age: _____
Primary Caregiver: _____
Contact #: _____
Notes:

Preferred Hospital _____
Alt Primary Caregiver/# _____
Emergency Contact/# _____
Physician/# _____

Glucose monitoring and management methods:

- ☐ Syringe/Vial
- ☐ CGM
- ☐ Glucose Meter
- ☐ Medication
- ☐ Insulin Pen
- ☐ Insulin Pump

Please provide:

Target Range:_____

CGM:_____

Insulin Pump: _____

Insulin Type(s) : _____

Meal and Snack/Carbs #	Insulin/Carb Ratio	Insulin Sensitivity/ Correction Factor/Scale	Low Blood Sugar Treatment Options

Hold Harmless Clause ☐ Yes, caregiver must administer insulin ☐No,client self-injects with supervision

I, _____ (Customer) hold harmless and indemnify _____ (caregiver), from and against any and all claims, loss, damage, injury, cost, charges, liability or exposure resulting from following the care instructions noted by the Client within this Individualized Care Plan(ICP). I certify the information within the ICP is complete and accurate. I understand caregiver services may be performed by an unskilled caregiver, experienced with diabetes care.

Signature: _____ Date: _____

Caregiver Checklist

(Review prior to Primary Caregiver departure)

(CHECK EXPIRATION DATE ON ALL SUPPLIES)

☐	**Insulin Vial (Count of 2)**	☐	**Glucose Meter**	☐	**Alcohol Prep-Pads**
☐	**Syringes (at least 2 per meal and 3 extra)**	☐	**Sufficient Test Strips**	☐	**Insulin pump and/or CGM site cover tapes**
☐	**Insulin Pen w/ full cartridge & pen tip needles (including backup for insulin pump)**	☐	**Penlet w/ lancets**	☐	**Sharps Container**
☐	**Insulin Pump with reservoir and infusion set. Next site change due date_____**	☐	**Ketone Strips**	☐	**Extra infusion set and reservoir**
☐	**Glucagon Kit or Nasal Spray**	☐	**Fully Completed ICP**	☐	**Extra pods for tubeless insulin pumps**
☐	**CGM Device with extra sensors Next site change due date_____**	☐	**Insulin regimen changes updated in ICP?**	☐	
☐	**Location of appropriate meal and snack foods**	☐	**Glucose gel, tablets or other source of rapid acting glucose**	☐	
☐	**Sugar free beverage locations**	☐	**Gloves**	☐	

Individualized Care Plan Instructions

The following instructions apply to people with Type 1 diabetes.

Client and contacts information

Date. Enter the date service is provided.

Name. Enter the first and last name of the client receiving services.

Age. Enter the age of the child at the time of service.

Primary Caregiver. Enter the name of the parent or guardian of the child.

Contact. Enter the telephone number of the primary caregiver.

Notes. Enter information needed to monitor and manage the client's condition, such as:

- Time of return
- Meal or snack time(s)
- Finger stick test times, if applicable
- Call preference when administering insulin, if applicable
- List dose and time for other oral medications, if applicable

Preferred Hospital. Provide the name and location of the preferred hospital in the event of an emergency.

Alt Primary Caregiver. Provide contact information for alternate primary caregiver.

Emergency Contact. Provide emergency contact in the event primary caregivers cannot be reached.

Physician. Provide the name and contact number of the healthcare provider of the child.

Glucose monitoring and management methods

Administration and monitoring methods. Check the box(es) for insulin administration systems and methods, and/or continuous glucose monitoring (CGM) devices used by the client.

Administration and monitoring additional information. Provide the following, if applicable:

- Target – The blood sugar target range of the client
- CGM– The name of the CGM device used by the client.
- Insulin Pump– The name of the insulin pump management system (e.g., T-Slim, Omnipod, etc.)
- Insulin Type – The name of the insulin brand (e.g., Novolog, Humalog, Lantus, etc.)

Meal and Snack/Carbs. Provide the meal/snacks and carb count for the Caregiver to properly cover the carbs consumed by the client.

Insulin/Carb Ratio. Provide the insulin to carb ratio for the caregiver to properly cover the carbs consumed by the client.

Correction Factor. Provide the correction factor needed to correct child's blood sugar levels when above the target range.

Low Blood Sugar Treatment Options. List approved snacks (e.g., juice, milk, candy, etc.) or methods (glucose tablets) to elevate low blood sugar levels.

Other. Provide any additional information needed to care for the client in the Notes section of the ICP form, such as other medications, behavioral difficulties, etc.

Signature and Date. Required by the Parent or guardian certifying the information provided accurately represents the medical regiment of the child, and agreement with the Hold Harmless Clause.

Caregiver Checklist

Checklist. The checklist is required to be completed by the Parent or guardian of the child and made presented to the Caregiver to review prior to providing caregiver services.

Additional Information. Provide additional information to the checklist as deemed appropriate.

DIABETES EQUIPMENT SUPPORT

WAIVER, RELEASE OF ALL CLAIMS AND HOLD HARMLESS AGREEMENT

READ CAREFULLY

I, _____(the client), agree _____the Diabetes Equipment Support Caregiver (The Caregiver), shall not be responsible to the Client or any third party for any loss, damage or injury resulting from, or in any way attributable to the operation of, use of, or any failure of the diabetes equipment. The Caregiver shall not be responsible for any defect or failure unknown to the Caregiver, while performing diabetes equipment site changes at the request of the Client.

I further agree to waive and relinquish all claims, loss, damage or injury incurred by my minor child/ward inconsequently as a result of receiving diabetes equipment support (i.e., site changes) from the Caregiver.

The terms of this agreement shall remain in effect and apply to all diabetes equipment support services performed by the Caregiver, on behalf of the Client.

I have read and fully understand the above Waiver and Release of all Claims and Assumption of Risk. I accept all of the terms and conditions set forth in this Agreement.

_____
Parent or Guardian Print Name

_____
Parent or Guardian Signature

Date_____

Individualized Care Plan (TYPE 2)

Date: _____
Client: _____
Client Age: _____
Primary Caregiver: _____
Contact #: _____
Notes:

Preferred Hospital

Alt Primary Caregiver/#

Emergency Contact/#

Physician/#

Main glucose monitoring and management methods:

- ☐ Syringe/Vial
- ☐ CGM
- ☐ Glucose Meter
- ☐ Medication
- ☐ Insulin Pen
- ☐ Insulin Pump

Please provide:

Target Range:_____

CGM:_____

Insulin Pump:_____

Insulin Type(s) :

_____

_____

Other Injectables:_____

_____

Meal and Snacks/Carb #	Insulin/ Carb Ratio	Insulin Sensitivity Correction Factor/Scale	Prescribed Insulin Dose	Low Blood Sugar Treatment Options

Hold Harmless Clause ☐ Yes, caregiver must administer insulin ☐No,client self-injects with supervision

I, _____ (Customer) hold harmless and indemnify _____ (caregiver), from and against any and all claims, loss, damage, injury, cost, charges, liability or exposure resulting from following the care instructions noted by the Client within this Individualized Care Plan(ICP). I certify the information within the ICP is complete and accurate. I understand caregiver services may be performed by an unskilled caregiver, experienced with diabetes care.

Signature: _____ Date: _____

Caregiver Checklist

(Review prior to Primary Caregiver departure)

☐	**Insulin Vial (Count of 2)**	☐	**Glucose Meter**	☐	**Alcohol Prep-Pads**
☐	**Syringes (at least 2 per meal and 3 extra)**	☐	**Sufficient Test Strips**	☐	**Insulin pump and/or CGM site cover tapes**
☐	**Insulin Pen w/ full cartridge & pen tip needles (including backup for insulin pump)**	☐	**Penlet w/ lancets**	☐	**Sharps Container**
☐	**Insulin Pump with reservoir and infusion set. Next site change due date_____**	☐	**Ketone Strips**	☐	**Extra infusion set and reservoir**
☐	**Glucagon Kit or Nasal Spray**	☐	**Fully Completed ICP**	☐	**Extra pods for tubeless insulin pumps**
☐	**CGM Device with extra sensors. Next site change due date_____**	☐	**Insulin regimen changes updated in ICP?**	☐	
☐	**Location of appropriate meal and snack foods**	☐	**Glucose gel, tablets or other source of rapid acting glucose**	☐	
☐	**Sugar free beverage locations**	☐	**Gloves**	☐	

Individualized Care Plan Instructions

The following instructions apply to people with Type 2 diabetes and require insulin. Client may have a set prescribed insulin dose and may not be using an insulin to carbohydrate ratio or correction factor.

Client and contacts information

Date. Enter the date service is provided.

Individual. Enter the first and last name of the client receiving services.

Age. Enter the age of the client at the time of service.

Primary Caregiver. Enter the name of the parent or guardian of the client.

Contact. Enter the telephone number of the primary caregiver.

Notes. Enter information needed to monitor and manage the client's condition, such as:

- Time of return, if applicable
- Meal or snack time(s)
- Finger stick test times for non-CGM users
- Call preference when administering insulin
- List dose and time for other oral medications

Preferred Hospital. Provide the name and location of the preferred hospital in the event of an emergency.

Alt Primary Caregiver. Provide contact information for alternate primary caregiver.

Emergency Contact. Provide emergency contact in the event primary caregivers cannot be reached.

Physician. Provide the name and contact number of the healthcare provider of the client.

Glucose monitoring and management methods

Administration and monitoring methods. Check the box(es) for insulin administration systems and methods, and/or continuous glucose monitoring (CGM) devices used by the client.

Administration and monitoring additional information. Provide the following, if applicable:

- Target – The blood sugar target range of the client
- CGM Device – The name of the CGM device used by the client.
- Pump System – The name of the insulin pump management system (e.g., T-Slim, Omnipod, etc.)
- Insulin Type – The name of the insulin brand (e.g., Novolog, Humalog, Lantus, etc.)
- Other Injectables – The name of medication (e.g., GLP -1 agonist, Victoza, Bydureon, etc.)

Meal and Snack/Carbs. Provide the meal/snacks and carb count for the Caregiver to properly cover the carbs consumed by the client.

Insulin/Carb Ratio. Provide the insulin to carb ratio for the to properly cover the carbs consumed by the client.

Correction Factor. Provide the correction factor needed to correct client's blood sugar levels when above the target range.

Low Blood Sugar Treatment Options. List approved snacks (e.g., juice, milk, candy, etc.) or methods (glucose tablets) to elevate low blood sugar levels.

Other. Provide any additional information needed to care for the client in the Comment or Notes section of the ICP form , such as other medications, behavioral difficulties, etc.

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Signature and Date. Required by the Parent or guardian certifying the information provided accurately represents the medical regiment of the client.

Caregiver Checklist

Checklist. The checklist is required to be completed by the Parent or guardian of the client and made presented to the Caregiver to review prior to providing caregiver services.

Additional Information. Provide additional information to the checklist as deemed appropriate.