

STUDENT DIABETES INFORMATION
(Medically Confidential Material)

PLEASE PRINT:

Student Name: _____ Date of Birth: _____
 Physician Name: _____ Physician Phone: _____
 Teacher Name: _____ School: _____

ATTACH COPY OF STUDENT EMERGENCY CARD FOR ADDITIONAL INFORMATION

DIABETES: a disorder involving primarily carbohydrate metabolism and characterized by deficiency of the hormone insulin.

Symptoms of HYPOGLYCEMIA (low blood sugar as a result of too much insulin, too little food, or too much exercise):

irritable, anxious poor concentration fatigue shaking sweating dizzy pale headache
 impaired vision slurred speech Other (please describe): _____

Procedure for HYPOGLYCEMIC Reaction: _____

Symptoms of HYPERGLYCEMIA (high blood sugar as a result of too little insulin or too much food):

extreme thirst frequent urination drowsiness blurred vision abdominal pain nausea vomiting
 Other (please describe): _____

Procedure for HYPERGLYCEMIC reaction: _____

Blood glucose monitoring:

Target range for blood glucose is _____ mg/dl to _____ mg/dl.
 Usual times to test blood glucose: At Home: _____ At School: _____
 Times to do extra blood glucose tests: (Check all that apply) Before exercise After exercise When student exhibits symptoms of hyperglycemia or hypoglycemia
 Blood sugar at which parent should be notified: Low _____ High _____

Daily management regimen

Insulin:

INSULIN	DOSAGE	TIME(S)	SITE	TAKEN AT SCHOOL	
1. _____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. _____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. _____	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Does student use a sliding scale for dosage of insulin? Yes No
 If **YES**, attach a copy of the scale.

Insulin pump:

TYPE OF PUMP	BASAL RATE	MEAL/SNACK BOLUS		CORRECTION BOLUS	
		Dosage	Time(s)	Dosage	Blood Glucose Level

Student's level of self-care:

- Totally independent management Yes No N/A
- Student tests blood glucose level independently Yes No N/A
- Student needs verification of blood glucose number by nurse or designated staff Yes No N/A
- Student administers insulin independently Yes No N/A
- Student self-injects insulin with verification of dosage by nurse or designated staff Yes No N/A
- Student monitors own snacks and meals Yes No N/A
- Snacks and meals need to be supervised Yes No N/A
- Student monitors own carbohydrate count Yes No N/A
- Student boluses for food and high blood sugar independently Yes No N/A
- Student boluses for food and high blood sugar with verification of # on pump by nurse or designated staff Yes No N/A

Dietary considerations:

School Snack AM: _____ School Snack PM: _____

Special Lunch Consideration: _____

- Diabetic supplies and equipment:** The parent/guardian shall provide the school nurse with:
- Blood glucose meter Yes No
 - Lancets, test strips Yes No
 - Syringes Yes No
 - Insulin Yes No
 - Glucose tablets Yes No
 - Snacks Yes No

Additional medications:

MEDICATION	DOSAGE	TIME(S)	TAKEN AT SCHOOL	
1. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Side effects to additional medication(s): _____

Special instructions from physician: _____

Release of information: The undersigned parent/guardian authorizes the release and/or exchange of medical information between the school nurse and my child's physician named above as it relates to this medical condition. I further authorize the school nurse to distribute copies of this document in accordance with the distribution list below to ensure the safe and proper care of my child while being transported to and from school as well as during school hours. I understand that professional staff will use the medical information given or received and that this information will not be released to any other party not designated herein.

Parent/Guardian Signature Date