DIABETIC INFORMATION

Student: Name _____ Grade_____

School _____

Parent/guardian: Name _____

Phone: Home_____ Work_____ Cell_____

Type of Diabetes_____

Type of Insulin Therapy (basal bolus injections, pump, split/mixed)_____

Can student give own injections? (if needed)_____

Time of Day for Snack (if needed)_____

Will blood sugar be tested during school hours?_____ **When?**_____

Will insulin be kept at school? Explain._____

<u>If your child will require medication during school hours a school medication form must be completed by the physician & parent.</u>

List Types of Insulin, Dosage, Times given _____

_____

Student's signs and symptoms of high blood sugar

_____

Action to take at school when blood sugar is high

_____

_____

Student's signs and symptoms of low blood sugar

_____

Action to take at school when blood sugar is low and signs and symptoms of low blood sugar

_____

_____

Parent Signature_____ **Date**_____