TULSA PUBLIC SCHOOLS
HEALTH SERVICES

DIABETIC INFORMATION

School _____ Grade _____ Date _____

Student _____ Date of Birth _____

Father _____ Work Phone _____ Home Phone _____

Mother _____ Work Phone _____ Home Phone _____

Alternate person to call in case of emergency:

Name _____ Relationship _____ Phone _____

Physician's Name _____ Phone _____

Address _____
Street City State Zip Code

Glucose Testing Method _____

Diabetic Medication dosage/time _____

Symptoms the student usually exhibits during an insulin reaction _____

_____

Time(s) of day reaction(s) most likely to occur _____

Parents' usual routine for treating insulin reactions _____

_____

Kind of morning or afternoon snacks _____

_____

_____ Date _____
Parent/Legal Guardian or Personal Responsible for Student's Care Signature

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