HOLY GHOST PREPARATORY SCHOOL
2429 BRISTOL PIKE, BENSALEM, PA 19020-5298 (215) 639-2102 • FAX (215) 639-4225
WWW.HOLYGHOSTPREP.ORG

DIABETES INFORMATION QUESTIONNAIRE

Student Name:_____ Grade:_____

Please complete the following questions so that the School Nurse can provide emergency care if needed.

What medications does your child take for Diabetes?

Name	Dose	Time	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Will your child need to take medication in school? Yes No

If YES, please explain_____

_____

How long has your child had Diabetes?_____

Does your child understand his/her Diabetes? Yes No

Will your child need a snack in school? Yes No

If your child has an insulin reaction in school, how would you like it treated?

_____

What symptoms does your child have when he/she starts experiencing an insulin reaction?

_____

Does your child recognize his/her own symptoms? Yes No

Will your child be doing blood sugar testing in school? Yes No

Do you give permission for the School Nurse to do blood sugar level if your child has symptoms of low sugar? Yes No

Would you like the School Nurse to explain Diabetes to your child's classmates or class? Yes No

Name of physician treating Diabetes:

_____ Telephone:_____

_____

Parent/Guardian Signature Date

HOLY GHOST PREPARATORY SCHOOL
2429 BRISTOL PIKE, BENSALEM, PA 19020-5298 (215) 639-2102 • FAX (215) 639-4225
WWW.HOLYGHOSTPREP.ORG

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

*Please note that all medications must be provided in the pharmacy labeled container or original OTC container.

This section to be completed by a parent/guardian:

School Year:_____

Student's Name:_____ Grade:_____

Health Care Provider:_____ Telephone:_____

I request that my child be assisted, by an authorized person, in taking the medication described below:

_____ _____ _____
Date Parent/Guardian Signature Telephone

****

The following is to be completed by the Health Care Provider:

Name of Medication:_____

Dose:_____ Time to be given:_____

If medication is to be given "WHEN NEEDED," describe indications:

_____

How soon can it be repeated?_____

Significant side effects:_____

_____

Other Information:_____

_____ _____
Date Health Care Provider Signature