RINGGOLD SCHOOL DISTRICT

Student Name_____ Grade_____

Dear Parent or Guardian,

Please return this Diabetes planning sheet in the enclosed envelope at least ***one week before school opens***. I will give the information to the teaching team and all special teachers before the first day of school.

Julie Clarvit, CSN

1. Daily Snack Time(s): AM_____ PM_____
2. Is a snack before gym class needed? NO YES
3. Where will the snack be eaten?: Classroom Health Office
4. Daily blood testing time(s): _____
5. What are the child's usual symptoms of low blood sugar?_____

   _____
6. Please describe the treatment plan for low or high blood sugars (or attach a written plan):

   If blood sugar is below_____

   _____

   _____

   If blood sugar is above_____

   _____

   _____
7. When should we call you about blood sugars?: Below_____ Above_____
8. Will juice boxes be sent for each classroom? NO YES
9. Will Glucagon be kept in school? NO YES (see attached medication form)
10. Will insulin be administered at school? NO YES (see attached medication form)
11. Other Instructions:_____

    _____

    _____