



Diabetes Intake Form

Student Name _____

School _____

Grade and Teacher _____

Parents/Guardians Name _____

Parents/Guardian Phone Number _____

When was the student diagnosed with Diabetes? _____

What Type of Diabetes _____

Who is the Dr/Facility that helps manage your diabetes? _____

What is the phone number of the Dr/Facility? _____

Have you provided physician orders for administration of all medications including insulin? _____

How independent are you in managing your diabetes? _____

Do you have an Insulin Pen or Pump? _____

What type of insulin is used in the pen or pump? _____

What is the brand name of the pump? _____

Do you take any oral medications to manage diabetes? _____

Do you have a sensor? _____ What type of sensor? _____

Does the sensor communicate/work together with the pump? _____

Do you have an account/user name for sensor apps so we can follow and monitor? _____

How often during the day do you take your blood glucose? _____

What do you feel like when you are low? _____

What do you feel like when you are high? _____

What is your current carb to insulin ratio? _____

Do you have emergency physician orders for dealing with low/high blood glucose levels?

What are those instructions? _____

Do you eat school lunch or pack your own lunch? _____

Do you dose your insulin after lunch or before? _____

Do you have a designated snack time in your class? _____

What time is your recess? _____

What time is your PE class? _____

Does the student have 504 Plan or SPED services? _____

What goal do you want to accomplish in helping manage your diabetes? _____

Please list Emergency Contacts in case parent/guardian is unavailable

Please provide these supplies in the clinic for successful management of diabetes.

- Glucometer with strips and lancets
- Ketone strips
- Glucose tabs
- Refillable water bottle
- Snacks for low blood sugar
- Glucagon or other emergency medication if possible