Diabetes

Date:____________

*Please fill out the following form and turn it in to your student's secretary. A new form must be completed every school year!

Student Name:____ DOB:___________________________

School:____ Teacher:__________________________

Does your student use the following? (Please check the box beside which device(s) they use and provide specific brands below.) Insulin Pump: ☐ CGM: ☐ Insulin pen: ☐ I-Port: ☐ Glucometer: ☐
Does your student have an app to track/monitor blood sugars? (Please specify which.) Yes: ☐ No:☐
What are the student's symptoms with a HIGH blood sugar? (Please check all that apply.)
Increased Thirst: ☐ Frequent Urination: ☐ Fatigue: ☐ Nausea/Vomiting: ☐ Shortness of breath: ☐ Stomach pain: ☐ Fruity breath odor: ☐ Very Dry Mouth: ☐ Rapid Heartbeat: ☐ Other: ___________________ ☐
What are the student's symptoms with a LOW blood sugar? (Please check all that apply.)
Shakiness: ☐ Nervousness: ☐ Anxiety: ☐ Fatigue: ☐ Weakness: ☐ Sweating: ☐ Hunger: ☐ Nausea: ☐ Dizzy/Lightheaded:☐ Difficulty Speaking:☐ Confusion: ☐ Other: _____________☐
What rescue medication does your student have? (Please check all that apply.) Glucagon (syringe/needle in red case): ☐ BAQSIMI (nasal spray): ☐ Gvoke (Injection):☐
Where is the student's Rescue Medication located? (Please check all that apply.) Office: ☐ Student's Backpack: ☐ Student's Locker: ☐ At home:☐
Where are Ketone test strips located for the student? (Please check all that apply.) Office: ☐ Student's Backpack: ☐ Student's Locker: ☐ At home: ☐
Has a Care Plan from your student's doctor been turned into the office for this school year? (Please note a new Care Plan is required every year. If one is not provided, important care for your child in an emergency situation may be delayed due to lack of information related to your student's health condition.) Yes: ☐ No: ☐

Additional Comments: ____

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Parent/Guardian Name (printed): ____

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Signature:____