Hypoglycemia

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:_____

What are your student's Hypoglycemia Symptoms? (Please check all that apply.)

Shakiness: ☐ Nervousness: ☐ Anxiety: ☐ Fatigue: ☐
Weakness: ☐ Sweating: ☐ Hunger: ☐ Nausea: ☐
Dizzy/Lightheaded: ☐ Difficulty Speaking: ☐ Confusion: ☐ Other: _____ ☐

Does your student use a glucometer/device to monitor their blood sugar? (If yes, please specify below.)
Yes: ☐ No: ☐

What does your student do to treat symptoms of a LOW blood sugar? (Please explain below.)

Where are supplies/treatment/snacks kept for your student? (Please check which apply.)
Office: ☐ Student Backpack: ☐ Student Locker: ☐

Do you have an Action Plan or Care Plan from your student's doctor for hypoglycemia? Yes: ☐ No: ☐

If the above answer was yes, has a copy been turned into your student's secretary? Yes: ☐ No: ☐

Additional Comments: _____
_____
_____
_____
_____

Parent/Guardian Name (printed): _____

Signature:_____