Diabetes Information Sheet

Student's Name:________________________________ Grade:___________ Date: ________________

Physician treating child's diabetes:_________________________________ Phone:________________

Date of Diagnosis:________________________

Diabetes Symptoms:

Usual signs/symptoms of high blood glucose (over ___________ mg/dl)

- ☐ Increased thirst, urination, appetite
- ☐ Blurred vision
- ☐ Tiredness/sleepiness
- ☐ Warm, dry or flushed skin
- ☐ Glazed over eyes
- ☐ Fruity breath
- ☐ Other___________________________

Usual signs/symptoms of low blood glucose (under ___________ mg/dl)

- ☐ Hunger
- ☐ Change in personality/behavior
- ☐ Paleness
- ☐ Weak/shaky
- ☐ Tired/sleepy
- ☐ Dizzy/staggering
- ☐ Headache
- ☐ Rapid heart rate
- ☐ Nausea/no appetite
- ☐ Sweating
- ☐ Blurred vision
- ☐ Confusion
- ☐ Slurred speech
- ☐ Loss of consciousness
- ☐ Seizure
- ☐ Other

Blood Glucose Monitoring

Can you child recognize their symptoms of hyper/hypoglycemia? ☐ Yes ☐ No

Can your child ordinarily perform his/her own blood glucose checks? ☐ Yes ☐ No

Can your child interpret the results? ☐ Yes ☐ No

Time blood glucose levels are to be checked:

- ☐ Before breakfast
- ☐ Before PE/Activity time
- ☐ Midmorning before snacks
- ☐ After PE/Activity time
- ☐ Before lunch
- ☐ Mid-afternoon
- ☐ Before 3:00p.m. dismissal
- ☐ Two hours after meals
- ☐ As needed
- ☐ Other ______________________

What is the target range for your child's blood glucose? ________mg/dl to ________mg/dl

Treatment

Will your child need insulin injections during the school day? ☐ Yes ☐ No

If yes, can he/she:

Determine correct dose? ☐ Yes ☐ No

Give their own injection? ☐ Yes ☐ No

Does you child use an insulin pump ☐ Yes ☐ No

If yes, is he/she:

Able to regulate the pump without assistance? ☐ Yes ☐ No

Participate in athletics with the pump connected? ☐ Yes ☐ No

Able to disconnect/reconnect the pump? ☐ Yes ☐ No

Will your child carry supplies to handle hypoglycemia? ☐ Yes ☐ No

Extra snacks may be needed:

- ☐ During sporting events/PE class
- ☐ Field Trips
- ☐ During exams
- ☐ On the morning or afternoon bus
- ☐ Time of day:______________________

Supplies to be furnished/restocked by parent/guardian:

- ☐ Blood glucose meter/strips/lancing device
- ☐ Ketone testing strips
- ☐ Sharps container for classroom
- ☐ Fast- acting carbohydrate______________________
- ☐ Carbohydrate containing snacks
- ☐ Carbohydrate-free beverage/snack
- ☐ Insulin vials/syringes
- ☐ Insulin pen
- ☐ Glucagon emergency kit
- ☐ Extra sites for pump

Does your child have dietary restrictions? ☐ Yes ☐ No

Please explain:____

Does your child understand his/her condition? ☐ Yes ☐ No

Comments: ____

Signature of parent/guardian:________________________________ Date:________________