Edmonds School District

Student Health Services

Diabetes Care Information Form

This information will be used to formulate a Life Threatening Emergency Care Plan that will be distributed to staff.

Student:_____ **DOB**: _____

School:_____ **Grade:** _____

Relation	Name	Phone	Phone	Email
Mother				
Father				
Emergency Contact				

HISTORY

Age of onset:_____ Last A1C:_____ Date:_____

Date of hospitalization: _____

Other illness or disability: _____

Does your student take the school bus to school: ☐ Yes ☐ No: _____

Physician who manages diabetes:_____ Phone _____

INSULIN DELIVERY

Injections ☐ Yes Humalog or Novolog? Target BG=_____ Correction Factor= _____

Insulin:Carb ratio B'fast_____:_____ Lunch_____:_____ Dinner_____:_____ Lantus or Levemir?_____u at_____am/pm

Pump ☐ Yes Type _____

CGM ☐ Yes Type _____

STUDENT'S SELF CARE ABILITY LEVEL

	Independent	Needs Assistance
Testing BG		
Counting Carbs		
Calculating insulin doses		
Administering Insulin		
Treating mild hypoglycemia		
Checking/interpreting ketones		
Changing pump site (if on pump)		

NUTRITION

What time does student eat breakfast?_____ What time does student get breakfast insulin? _____

Does your student: Bring lunch from home? ☐ Buy lunch from school? ☐

Does your student require a snack between meals? ☐ No ☐ Yes When?_____

Is your student compliant with diet? ☐ Yes ☐ No: _____

EXERCISE

Ever experience low BG's with PE or activity? ☐ No ☐ Yes: _____

Does your student need a snack before physical activity? ☐ No ☐ Yes: _____

Involved in after school activities at school (ie: YMCA)? ☐ No ☐ Yes: _____

SYMPTOMS LOW BLOOD SUGAR: (Check symptoms that your student has experienced)

☐ weakness ☐ hunger ☐ shaky ☐ fast heartbeat ☐ sweating ☐ anxious ☐ dizzy ☐ drowsy

☐ pale skin ☐ irritable ☐ lack of concentration/daydreaming ☐ other _____

☐ headache ☐ blurry vision ☐ confusion ☐ poor coordination ☐ slurred speech ☐ weakness

☐ behavior change: _____

☐ loss of consciousness: When? _____

GLUCAGON DOSE: _____

At what blood glucose level do symptoms appear? _____

Can your student recognize hypoglycemia? ☐ No ☐ Yes _____

When has student experienced hypoglycemia? _____

Has your student ever **not** responded to treatment: ☐ No ☐ Yes _____

TREATMENT OF LOW BLOOD SUGAR (what works for your child?)

For BG<_____Treat with:_____Carbs (ie(ie:_____)

For BG<_____Treat with:_____Carbs (ie:_____)

Call parents:

☐ after 1st treatment and still symptomatic ☐ after 2nd treatment and still symptomatic ☐ any time BG <

_____

SYMPTOMS OF HIGH BLOOD SUGAR: (Check symptoms your student has experienced)

☐ thirst ☐ frequent urination ☐ fatigue ☐ sleepy ☐ increased hunger ☐ sweet breath ☐ blurred vision

☐ weight loss ☐ stomach pains ☐ flushing of skin ☐ lack of concentration ☐ dry mouth ☐ nausea

☐ stomach cramps ☐ vomiting ☐ labored breathing ☐ very weak ☐ confused ☐ unconscious

☐ other _____

TREATMENT OF HIGH BLOOD SUGAR

☐ drink water ☐ exercise ☐ Insulin correction (if >3 hours from last dose)

☐ check ketones if BG >_____(Parent will be called if moderate to large ketones present to take student home for Sick Day care.

_____ _____

Parent Signature **Date**