Report on a Student with Diabetes

(LAST NAME) (FIRST) (MIDDLE) (DOB) (ID #)

(HOME ADDRESS) (ZIP CODE) (TELEPHONE)

(PARENT'S/ GUARDIAN'S NAME) (SCHOOL)

Blood Glucose Monitoring

Student Diagnosis: □ Type 1 Diabetes □ Type 2 Diabetes on ____________________
Date

Target blood glucose __________ mg/dl **Usual Time (s) to check blood glucose** ______________

Times to do extra blood glucose checks (*check all that apply*)
□ Before exercise □ After exercise □ When student exhibits symptoms of hyper/hypoglycemia

□ **Yes** □ **No** Student can perform their own glucose checks?
Type of meter used: ______________________________

Insulin / Oral Medication Requirements

□ **Yes** □ **No** Oral Medications used to manage Diabetes? Type ______________at __________________
Time

□ **Yes** □ **No** Insulin is used to manage Diabetes? Type ___________Units at________________
Time

□ **Yes** □ **No** Student requires Insulin on Sliding Scale? Type of Insulin _________________________
□ **Yes** □ **No** Student can give their own injections?

_____ units if blood glucose is _____ to _____ mg/dl
_____units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl

For Students with Insulin Pumps Only:
□ **Yes** □ **No** Insulin Pump used to manage diabetes? **Type of pump:** _________________________
□ **Yes** □ **No** Student independent in insulin pump management?
Basal Rates: ____ 12am to ____, ____ ____ to ____, ____ ____ to ____, ____ ____to ____
rate time rate time time rate time time rate time time
Insulin / Carbohydrate ratio: ____________________ Correction factor: ________________________

Meals and Snacks

□ **Yes** □ **No** Carbohydrate calculations required for management? □**Yes** □ **No** Student is independent

TIME	*FOOD CONTENT / AMOUNT*	*TIME*	*FOOD CONTENT / AMOUNT*
Breakfast		**Mid-Morning**	
Lunch		**Mid-Afternoon**	

Next appointment date: ________________

Special Instructions, if any: ____

Provider's Name_____________________________________ **Hospital Affiliation** ____________________
(Please print or type)
Address ____**Telephone #** _______________**Fax#**__________

Provider's Signature ____**Date**______________