DIABETES HISTORY FORM

Date______________________________
Student's Name___________________________________ DOB_________________Grade_________
Primary Healthcare Provider: ____ Phone: ________________
Endocrinologist: ____Phone: ________________

Please note: Students requiring specific health services at school are required to have a Diabetic Treatment and Management Plan (provided and signed by a physician), and all necessary supplies, medication, and medication request forms prior to the first day of school.

Does your child have a Section 504 Plan for this health condition? Yes ____ No _____

What type of diabetes has a healthcare provider diagnosed your child?

- Type I Diabetes
- Type II Diabetes

What age was your child diagnosed with diabetes? _____
Has your child been prescribed insulin for the treatment of diabetes? Yes ____ No ____
Has your child been prescribed medication for the treatment of diabetes? No ____ Yes ____

List all medications prescribed for your child:

Medication Name	Dosage	Frequency	Will this medication be given at school Yes/No

What was your child's last A1C?

What is your child's self-care level for his/her diabetes at school?
____ Independent management ____ Assistance from staff ____ Complete care from staff

What are your child's usual symptoms of hypoglycemia? ____
____

What are your child's usual symptoms of hyperglycemia? ____
____

Has your child required an emergency room visit or been hospitalized due to his/her diabetes?
___ Yes ___ No If yes, what were the dates____
Please explain ____
Additional information:
____
____

Parent/Guardian Name:____Date: ____________________
Parent Guardian Signature: ______________________________________
Reviewed by RN: ____ Date: ____________________________