DISTRICT 4J SCHOOLS
HEALTH SERVICES

Student Name ______________________________________ School ___________________

Date of Birth ___________________________ Date ______________ Grade _____________

DIABETES ASSESSMENT

You have checked on school records that this student has **diabetes**. It is important to have current health information & direction when she/he needs help at school. Please complete this form & return it to your child's school so that appropriate instructions may be given to school personnel. Please contact your school nurse.

CHECK SYMPTOMS USUALLY PRESENT IN THIS STUDENT'S LOW BLOOD SUGAR REACTIONS:

_____Mood changes (circle the usual): irritability crying confusion inappropriate responses

____Headache ____ unusually pale, moist, clammy skin ____shaky,nervous ____dizziness

____blurred vision ____Numbness, tingling lips/tongue ____drowsiness,fatigue ____loss of consciousness

____Other ____

How often does a low blood sugar reaction occur? ____

Most recent hospitalization/emergency room visit for diabetes? ____

Diabetes is currently being treated by Dr. ________________________________ Phone _________________

List measures needed at school to help prevent a hypoglycemic reaction. (include directions for meals and snacks at school.) ____

Do blood sugar tests need to be done at school? ___No ___Yes (When?_________________________________)

Does the child need assistance with blood sugar test? ___No ___Yes Diabetes management? ____No ___Yes

Will insulin be taken at school? ___No ___Yes ____Pen _____Shot ____Pump (type)___________________

If ordered, will glucagon be provided to the school for severe hypoglycemia? _____No _____Yes

Does your child ride the school bus? ___No ___Yes Does your child participate in school sports? ___No ___Yes

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THE USUAL PLAN AT SCHOOL FOR A STUDENT HAVING LOW BLOOD SUGAR PROBLEM IS:

Precautions taken:

1. If unsure whether problem is low blood sugar or high blood sugar, it is assumed to be low blood sugar and treated accordingly. Check blood sugar if possible.
2. Never attempt to give food or liquid to a student who is unconscious or having a seizure.

Action taken:

1. If conscious, give one of the following: ½ cup juice, 4 round glucose tabs, glucose gel, or other fast acting sugar supplied by parent. Do not leave student alone.
2. If symptoms do not improve in 15 minutes repeat the above.
3. If symptoms don't improve after second feeding repeat sugar treatment, call parent, continue to monitor
4. After symptoms subside check student care plan to see if extra snack is needed.

Emergency action:

1. If student becomes unconscious, has a seizure or is unable to swallow, call 911. If glucagon kit provided, a trained staff person should give.
2. Notify parents at once if 911 is called

Continue to Side 2

Student Name____

Parent/Guardian Contact #1	Emergency Contact #2	Emergency Contact #3
Name ________________________	Name___________________________	Name_________________________
Relationship____________________	Relationship______________________	Relationship____________________
Address_______________________	Address__________________________	Address_______________________
Phone: (H)_________(W)_________	Phone: (H)_________(W)____________	Phone: (H)_________(W)_________
Cell__________________________	Cell____________________________	Cell__________________________

AMBULANCE PERMIT

I give consent for the school principal, school nurse, or other school personnel to use their judgment in securing further medical aid and to call an ambulance to take my (son, daughter) ________________________________ to ________________________________Hospital in case parent/legal guardian cannot be reached.

The above information may be shared with ambulance personnel. **PERMISSION:___YES___NO**

To provide for your child's safety and educational experience the above information will be shared with school staff, included in your child's school health record and may be shared electronically.

______________________________________ ________________________________

Signature of Parent/Guardian Date (Valid One Year)

RETURN THIS FORM TO THE SCHOOL

	DATE	SIGN / INITIAL
STUDENT COMPUTER SYSTEM ENTRY	____________________	______________________
INFORMATION SHARED WITH STAFF	____________________	______________________

Additional notes:____

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