RIDGEFIELD SCHOOL DISTRICT HEALTH SERVICES

Diabetes History Form

for_____School Year

Student Name: _____ Date of Birth: _____ Gender: M / F Grade ____

Parent Contact: _____ Ph. Number: _____(home) _____(work/cell)

☐ My child has been diagnosed with **TYPE 1 Diabetes**
☐ My child has been diagnosed with **TYPE 2 Diabetes**
☐ My child has been hospitalized for diabetes Date: _____ Why: _____
☐ My child has been seen in the ER and released Date: _____ Why: _____

Physician/LHP: _____ Phone Number: _____

***Please fill out the following information to help us help your child manage their diabetes while at school**

What age was you child diagnosed with diabetes? _____
Do you or your child have any concerns about managing his/her diabetes in school ☐Yes ☐No
If yes please explain: _____
_____

How well does your child manage his/her everyday needs for diabetic management?

- Ability to recognize **EARLY** signs of low blood sugar? ☐Poor ☐Fair ☐Good
- Nutrition ☐Poor ☐Fair ☐Good
- Exercise ☐Poor ☐Fair ☐Good
- Medication ☐Poor ☐Fair ☐Good

What have you found is the best way to help your child adjust to any changes due to diabetes?
_____
_____

Does your child:

- Stick their finger to test blood sugar ☐Yes ☐No
- Know how to use a meter? ☐Yes ☐No
- Interpret results and know what actions to take? ☐Yes ☐No
- Use an insulin pump? ☐Yes ☐No
- Draw up his/her own insulin? ☐Yes ☐No
- Give the injection? ☐Yes ☐No

Please list **all** you child's **medications:**

	Medication	Dose	Time
	_____	_____	_____
	_____	_____	_____

Insulin:	Type of Insulin	Dose	Time
	_____	_____	_____
	_____	_____	_____

Sliding Scale:	Blood Glucose Range	Insulin Type and Dose
	_____	_____
	_____	_____

Parent/Guardian Signature: _____ Date: _____