DIABETIC CHECKLIST

1. Name of student ___________________________________ Grade _____ Teacher ______________

2. Type of diabetes: ____

3. Physician treating the child's diabetes: _____________________________ Phone : _____________

4. Insulin: Type ____________________ Amount ___________Time(s) given ________________

   Type ____________________ Amount ___________ Time(s) given ________________

   Type ____________________ Amount ___________ Time(s) given ________________

5. Is blood sugar testing to be done at school? Yes _____ No _____

   Time(s) to be tested ____

   May we test your child at other times? Yes _____ No _____

   Is your child able to do the blood sugar testing without help? Yes _____ No _____

6. Are ketones to be tested in school? Yes _____ No _____

   Time(s) to be tested ____

   Is your child able to test ketones without help? Yes _____ No _____

7. Will insulin and syringes be kept at school? Yes _____ No _____

- **All medications** kept at school require medication forms signed by your child's physician and a parent/guardian.
  Medication must be provided by the parent/guardian.

8. Is your child able to draw up and self-administer insulin? Yes ____ No _____

9. Does your child require a snack? Yes _____ No _____

   What time(s) should a snack be eaten? ____

   Where do you prefer snacks be eaten? Classroom _____ Office _____

10. What are your child's special dietary needs? ____

11. What are your child's symptoms of high blood sugar? _______________________________________
    What treatment is needed? ____

12. What are your child's symptoms of low blood sugar? ______________________________________ What treatment is needed? ____

Other comments: ____

SIGNATURE ____ DATE_________________