

Diabetes Form



CHIPPEWA VALLEY SCHOOLS

19120 Cass Avenue, Clinton Township, MI 48038

(586) 723-2000 FAX (586) 723-2001

"Chippewa Valley Schools...preparing students today for the challenges of tomorrow"

TO BE COMPLETED BY PARENT/GUARDIAN

Student: _____ Birth Date: _____

School: _____

Grade/Room: _____

School day time: _____

Physical Education Days and Times: _____

Will your child ride the bus to and from school? Yes _____ No _____

Will your child attend before or after day care at school? Yes _____ No _____

If yes, what days and times? _____

Extracurricular school activities: _____

Student's low blood sugar symptoms: _____

Student's high blood sugar symptoms: _____

STUDENT SHOULD NEVER BE LEFT ALONE IF HAVING SYMPTOMS OF HIGH OR LOW BLOOD SUGAR. LOW OR HIGH BLOOD SUGAR MAY CAUSE CONFUSION.

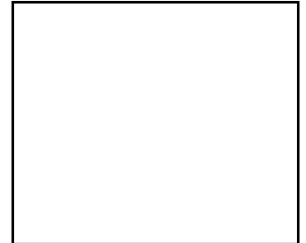
The student is responsible for providing the Glucometer and testing supplies.

Parent/guardian telephone numbers: Home _____ Work _____

Cell _____ Other _____

Parent/Guardian Signature _____

Date _____



STUDENT PICTURE

SEE SECOND PAGE

TO BE COMPLETED BY STUDENT'S PHYSICIAN

The designated blood testing area in the school is a private room off the school office. Student should check blood sugar (please indicate times and circumstances).

Before lunch Yes _____ No _____
Other times When? _____ When? _____
 When? _____ When? _____

IF BLOOD SUGAR READING IS	PERFORM THIS ACTION

At what times are snacks required each day?

Other recommendations:

School staff will receive training regarding diabetes, provided by the school nurse and will receive a copy of this plan and the attached Signs of a Diabetic Emergency. Designated school staff will monitor and assist the student as needed.

Physician's Signature

Date

Physician's Name

Telephone Number

Address

Fax Telephone Number

City, State, Zip Code