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 PICTURE

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

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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