HEALTH SERVICES
LANCASTER SCHOOL DISTRICT

DIABETIC ASSESSMENT

NAME:	AGE:	DATE:
SCHOOL:	GRADE:	BIRTHDATE:
AGE DIAGNOSED:	DATE OF LAST PHYSICAL EXAMINATION:	

SCHOOLDAY ROUTINE: INDICATE TIME AND LOCATION OF BLOOD GLUCOSE TESTING, INSULIN ADMINSTRATION AND MEALS

MORNING:

MID-MORNING SNACK:

DINNERTIME:

EVENING:

DOES CHILD EAT SCHOOL PREPARED BREAKFAST OR LUNCH?

METHOD OF TRANSPORTATION TO & FROM SCHOOL:

IS CHILD ABLE TO CHECK BLOOD SUGARS?

SELF-ADMINISTER INSULIN?

SIGNS / SYMTOMS OF LOW BLOOD SUGAR FOR THIS CHILD:

TREATMENT FOR LOW BLOOD SUGAR; LIST BLOOD LEVELS AND TYPE AMOUNT OF SUGAR / FOODS TO BE GIVEN IF POSSIBLE:		
SIGNS / SYMPTOMS OF HIGH BLOOD SUGAR FOR THIS CHILD, AND TREATMENT:		
DOES CHILD CARRY OWN SUGAR SUPPLY?		
TREATMENTS / PROCEDURES REQUIRED DURING SCHOOLDAY:		
BLOOD GLUCOSE MONITORING:	YES	NO
INSULIN ADMINISTRATION:	YES	NO
GLUCAGON FOR EMERGENCY USE:	YES	NO
IF YOUR CHILD REQUIRES ANY OF THE ABOVE TREATMENTS / PROCEDURES, PLEAE BE ADVISED THAT THE SCHOOL MUST HAVE ALL THE REQUIRED PERMISSION FORMS SIGNED BY BOTH THE DOCTOR AND THE PARENT BEFORE THE CHILD CAN ATTEND SCHOOL. ADDITIONALLY, THE PARENT IS REQUIRED TO SUPPLY THE FLUIDS / FOODS REQUIRED TO TREAT LOW BLOOD SUGAR, AS WELL AS BLOOD TESTING EQUIPMENT AND MEDICATIONS.		
EMERGENCY INFORMATION:		
PARENTS: MOTHERS NAME:		
ADDRESS:		
HOME PHONE:	WORK PHONE:	
FATHERS NAME:		
ADDRESS:		
HOME PHONE:	WORK PHONE:	
RELATIVES / FRIENDS WHO AE AUTHORIZED TO PICK CHILD UP FROM SCHOOL		
NAME:	RELATIONSHIP:	PHONE #
NAME:	RELATIONSHIP:	PHONE #
NAME:	RELATIONSHIP:	PHONE #
PHYSICIAN NAME:		
ADDRESS:		
PHONE NUMBER:		