LAWTON PUBLIC SCHOOLS - DIABETES HEALTH FORM

Student Name: _____ **Date of Birth**_____

School: _____ **Grade:** _____

Diagnosis: □ **Type 1** □ **Type 2** **Date of Diagnosis:** _____

Parent/Guardian #1: _____ Address: _____

Telephone: Home _____Work _____Cell_____

Parent/Guardian #2: _____ Address: _____

Telephone: Home _____Work _____Cell_____

Emergency Contact: _____ Address: _____

Telephone: Home _____Work _____Cell_____

Doctor/Health Care Provider: _____Telephone: _____

Hospital Of Choice: □ Comanche County Memorial □ Southwestern □ Reynolds □ Lawton Indian

BLOOD GLUCOSE MONTORING:

*Target range for blood glucose: _____ to _____.
*Usual time to test blood glucose during school: □ before lunch □ before breakfast
*Times to do extra blood glucose checks: □ before exercise □ after exercise □ symptoms of hypoglycemia or hyperglycemia □ other (explain): _____
*Can student perform own blood glucose checks? □ Yes □ No □ Needs assistance

INSULIN

*Type of insulin ordered: □ Humalog □ Novolog □ Apidra □ Regular □ Other _____

BREAKFAST DOSE

*Carbohydrate ratio: 1 unit of insulin per _____ grams of carbohydrates.
*Blood sugar correction factor: 1 unit of insulin for every _____ points above _____.

LUNCH DOSE

*Carbohydrate ratio: 1 unit of insulin per _____ grams of carbohydrates.
*Blood sugar correction factor: 1 unit of insulin for every _____ points above _____.

*Please indicate which method is used by the student: □ Syringe □ Pen □ Pump
*Can student administer insulin independently? □ Yes □ No □ Needs Assistance
*Can student determine correct amount of insulin to inject? □ Yes □ No □ Needs Assistance
*Can student draw correct dose of insulin? □ Yes □ No □ Needs Assistance

*** Any adjustments to student's carbohydrate ratio or blood sugar correction factor must be made by physician and medical documentation must be provided (LPS form #1).

STUDENTS WITH INSULIN PUMPS

*Type of Pump: _____ Insulin ordered in pump:_____
*Is student capable of bolusing correct amount for carbohydrates eaten? □ Yes □ No □ Needs Assistance
*Is student capable of troubleshooting alarms and malfunctions? □ Yes □ No □ Needs Assistance

STUDENTS TAKING ORAL DIABETES MEDICATIONS

Name of Medication: _____ Time taken: _____

*Does his/her diabetes cause the student to be absent more often from school? □ Yes □ No
If yes, please explain _____

MEALS AND SNACKS EATEN IN SCHOOL

*Is the student independent in carbohydrate calculations and management? □ Yes □ No □ Needs Assistance
*If insulin is to be given for snack at school, indicate amount to be used for correction:
Carbohydrate ratio: _____ Blood sugar correction factor: _____
*Will student need snack before exercise? □ Yes □ No
*Will student need snack after exercise? □ Yes □ No
*Please list preferred snack foods: _____
*Foods to avoid, if any: _____

EXERCISE AND SPORTS

*The following foods will be provided (per parents) for the student at the site of exercise or sports: _____
_____
*Restrictions on activity, if any: _____
*Student should ***not*** exercise if blood glucose level is **BELOW** _____ mg/dl or **ABOVE** _____mg/dl.

HYPOGLYCEMIA (Low Blood Sugar)

*Symptoms include: □ Tiredness □ Sweaty □ Shaky □ Clammy □ Dizzy □ Headache □ Hunger □ Sleepy
□ Lethargic □ Irritable □ Confusion □ Other_____
*Treatment of Hypoglycemia: _____

*Glucagon should be given if the student is unconscious, having a seizure, or unable to swallow. □ Yes □ No
***Administer Glucagon: Dosage _____ mg SQ or IM. (LPS form #1 must also be completed).

HYPERGLYCEMIA (High Blood Sugar)

*Symptoms include: □ Thirsty □ Frequent urination □ Blurry vision □ Irritable □ Hyperactivity □ Headache
□ Hunger □ Nausea/Vomiting □ Cramping □ Dizzy □ Other _____
*Treatment of Hyperglycemia: _____

*Ketones should be checked when blood glucose levels are above _____ mg/dl.
* ***Trace to Small ketones***:
- Encourage water or sugar-free liquids
- ***Light*** Exercise only
- Notify Parent/Guardian
- Recheck blood sugar and ketones in (2) hours – if no decrease in blood sugar or increase in ketones, call parent/guardian to pick up student.

* ***Moderate to Large Ketones***
- Student will stay in office and rest. No exercise.
- Notify Parent/Guardian to ***immediately*** pick up student.
- Offer water or sugar free liquids.

This Diabetes Health Form has been approved by:

Physician Name/Title: _____ (Please print or type)

Physician Signature: _____ Date: _____

Telephone: _____ Fax: _____ Address: _____

_____ _____

Parent/Guardian Signature Date