Campus: ______________

Date: _________________

BEEVILLE
INDEPENDENT SCHOOL DISTRICT
INSPIRING BOLD INNOVATIVE LEADERS

HEALTH DATA COLLECTION FORM – DIABETES

(To be completed by parent and school nurse. Refer to diabetes medical management care plan for doctor's orders. Review/Communicate with parent/guardian as needed for updates or changes to ordered plan).

Student Name: ___________________________ **Date of Birth:** _________ **Grade:** ____ **Student ID:** ______

Student is allergic to (include medications, food, etc): ____
____

Emergency Contacts:
Mother/guardian name:______________________________
Work Number: __________________ Cell Number: ________________________
Father/Guardian name: ______________________________
Work Number: _________________ Cell Number: ________________________
Other Name, phone number and relation: ___________________________________
____

Physicians:
Pediatrician: _________________________ Phone Number: __________________
Specialist: ____________________________ Phone Number: __________________
Last Hospital Admission date: _______________ Hospital name: ________________________________

Medical Diagnosis (list all health diagnosis for child): ____
____

Medications (list all medications given at home and at school): ____
____
____

- Age at diagnosis of diabetes: _____________ Please circle one: Type 1 or Type 2
- Physician authorization form given to parents (can be picked up at school or printed from Beevilleisd.net):
  ___Yes ___No Completed form returned from parents to nurse: ___Yes ___No
- Physician prescribed Diabetes Medical Management Plan received (please provide a complete and signed copy to the school nurse): ______Yes _______ No

Blood sugar monitoring:

When: ___________________________

Where: __________________________

Who (comment on level of independence and who will monitor in nurse's absence):
____
____

Intervention for blood sugar levels (provide copy of parameter information from physician):
____
____

Insulin:

At home:

Type: ____

Number of units: _________________________________

Administration time: ______________________________

At school:

Type: ____

Number of units: _________________________________

Administration time: ______________________________

Who will administer: ______________________________

Comments: ____

____

Snacks:

Type: ____

Administration time: ______________________________

Where will snacks be kept: _________________________

Fluid intake: ____

Dietary restrictions: ____

Physical activity restrictions: ____

Assistive devices (ex: glasses, hearing aides, wheelchair, braces, walker): _________________________________
____

Does your child need any special assistance): ____
____

Additional Information: ____
____
____

Physicians:

Pediatrician: ________________________ Phone Number: ________________________

Endocrinologist: _____________________ Phone Number: ________________________

Hospital Preference: __________________ Phone Number: ________________________

Data collected by: ________________________________ Date: _____________________

(Parent/Guardian Signature)

Reviewed by: ____________________________________ Date: _____________________

(School Nurse Signature)