DIABETIC CHECKLIST

1. Name of student _____ Grade _____ Teacher _____

2. Type of diabetes: _____

3. Physician treating the child's diabetes: _____ Phone : _____

4. Insulin: Type _____ Amount _____Time(s) given _____

   Type _____ Amount _____ Time(s) given _____

   Type _____ Amount _____ Time(s) given _____

5. Is blood sugar testing to be done at school? Yes _____ No _____

   Time(s) to be tested _____

   May we test your child at other times? Yes _____ No _____

   Is your child able to do the blood sugar testing without help? Yes _____ No _____

6. Are ketones to be tested in school? Yes _____ No _____

   Time(s) to be tested _____

   Is your child able to test ketones without help? Yes _____ No _____

7. Will insulin and syringes be kept at school? Yes _____ No _____

- **All medications** kept at school require medication forms signed by your child's physician and a parent/guardian.
  Medication must be provided by the parent/guardian.

8. Is your child able to draw up and self-administer insulin? Yes ____ No _____

9. Does your child require a snack? Yes _____ No _____

   What time(s) should a snack be eaten? _____

   Where do you prefer snacks be eaten? Classroom _____ Office _____

10. What are your child's special dietary needs? _____

11. What are your child's symptoms of high blood sugar? _____
    What treatment is needed? _____

12. What are your child's symptoms of low blood sugar? _____ What treatment is needed? _____

Other comments: _____

SIGNATURE _____ DATE_____