

## Diabetic Monitoring Sheet

Student's name: \_\_\_\_\_ Wears medical identification Yes \_\_\_ No \_\_\_

Parent/Guardian's name \_\_\_\_\_ Phone \_\_\_\_\_

Teacher's name \_\_\_\_\_ Grade \_\_\_\_\_

(Parent/Guardian will be notified of any findings that are different from what is noted below \*)

My child is under the care of Dr. \_\_\_\_\_ Phone # \_\_\_\_\_

Date/age of diagnosis \_\_\_\_\_ Next doctor's appointment \_\_\_\_\_

My child can test his/her blood sugar with: \_\_\_ No help **or** \_\_\_ Needs some help

### Glucose monitoring:

Blood sugars to be done at \_\_\_\_\_ before lunch. Blood sugars should be between \_\_\_\_\_ and \_\_\_\_\_. \* A daily log of blood sugars will be kept by the nurse.

If blood sugar is **below** \_\_\_\_\_ please give one of the following:

\_\_\_ 4 oz. orange juice. \_\_\_ glucose tabs. Parent preference: \_\_\_\_\_

If blood sugar is **above** \_\_\_\_\_ encourage child to drink water during the afternoon.

If blood sugar is **above** \_\_\_\_\_ check ketones prior to exercise.

My child's signs and symptoms when blood sugar is **low**: \_\_\_\_\_

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My child's signs and symptoms when blood sugar is **high**: \_\_\_\_\_

My child's insulin doses and times are as follows: \_\_\_\_\_

Snack times are \_\_\_\_\_ and \_\_\_\_\_. If my child does not have a snack he/she can have:

(please include amounts) \_\_\_\_\_

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Allergies (if any) \_\_\_\_\_

**Emergency Glucagon is stored in the nurse's office. Please see nurse as to where it is located.**

All supplies for care will be provided by parent.

Yes, I give permission for my child's teacher to be made aware of my child's health needs and to be updated as needed. I also give the nurse permission to speak with his/her doctor as needed along with parent notification.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_