



Galloway Township Public Schools
 101 South Reeds Road
 Galloway, NJ 08205
 (609) 748-1250
<http://www.gtps.k12.nj.us>

Diabetes Questionnaire

You have informed the school nurse that your child has diabetes. In cooperation with your child's physician, please complete the information below and return it to the school nurse. **This form is only valid for the current school year.**

Student's Name _____ Date of Birth _____ Grade _____

MEDICAL HISTORY: (To be completed by parent/guardian and physician)

Blood Glucose

Target range for blood glucose: _____ mg/dl to _____ mg/dl

Glycohemoglobin A1C result: _____ Date: _____

Usual times to test blood glucose (check all that apply):

_____ before breakfast	_____ before lunch	_____ before dinner
_____ before exercise	_____ after exercise	_____ PRN

Can child perform their own blood glucose tests? Yes No

Type of meter: _____

Ketones: Urine _____ Blood _____

Circumstances for testing: _____

Date of last eye examination: _____ Physician: _____

Insulin

Times, type and dosages of insulin injections taken:

<u>Time:</u>	<u>Type:</u>	<u>Dosage:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Medications: _____

Additional Information Required on Reverse Side>>>>>

"Where Children and Learning Come First"

Meals and Snacks

<u>Meals and Snacks:</u>	<u>Time:</u>	<u>Food Content/Amount:</u>
Breakfast	_____	_____
Midmorning Snack	_____	_____
Lunch	_____	_____
Midafternoon Snack	_____	_____
Other times to give snacks	_____	_____

Preferred snack foods: _____

Foods to avoid, if any: _____

Exercise and Sports

A snack such as _____ should be readily available during exercise and sports.

Restrictions on activity, if any: _____

Child should not exercise if blood sugar is: _____

Hypoglycemia

Usual symptoms of hypoglycemia: _____

Treatment of hypoglycemia: _____

If glucagon is to be given please list the dose, route and side effects (If glucagon is given, 911 will be activated and parents/guardians notified immediately): _____

Hyperglycemia

Usual symptoms of hyperglycemia: _____

Treatment of hyperglycemia: _____

Physician/Health Care Provider Signature/Stamp Date

Please Print Physician/Health Care Provider's Name, Address, and Phone Number

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Emergency Phone Numbers

Mother: Home _____ Work _____

Father: Home _____ Work _____

Other: Name _____ Relationship _____

 Home _____ Work _____

Doctor/Health Care Provider _____ Phone _____

Preferred Hospital: _____

Parent/Guardian's Signature Date