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

Glycohemoglobulin 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:

Time:	Type:	Dosage:
____	_____	_____
____	_____	_____
____	_____	_____

Other Medications: _____

Additional Information Required on Reverse Side>>>>>

"Where Children and Learning Come First"

Meals and Snacks

Meals and Snacks:	Time:	Food Content/Amount:
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

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