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

Diabetes Questionnaire/Action Plan

Dear Parent/Guardian:

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:

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

Other Medications: _____

Additional Information Required on Reverse Side>>>>>

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 administered, 911 will be activated and parents/guardians will be 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 _____
Preferred hospital: _____

In the absence of the school nurse, I grant permission **for a trained delegate to administer my child's glucagon** as medically ordered. I understand that if the specified procedures are followed, the district, its employees and agents shall have no liability as a result of any injury arising from the administration of glucagon to my child.

_____ _____
Parent's/Guardian's Signature Date