Diabetes Medical Management Intake Form

General Info:

Name:	Name of School:
Date of Birth:	School RN name/email:
Type of Diabetes:	School Fax Number:

Self Management Skills: Based on your child's ability please list if your child does each skill below with

Staff must do **With supervision** **Independent**

Checks blood sugar:	Calculate insulin dose:
Carb count:	Manage low blood sugar: Symptoms:
Administers Insulin: (pen, syringe, or pump)	Manage high blood sugar: Symptoms:

All symptoms of high/lows blood sugars will be checked off as a default, and state that symptoms vary based on the student, per parent. If there are specific symptoms that the child experiences, please list them above.

Monitoring: All forms will default to check BS before meals, physical complaints of illness & high or low glucose symptoms. If there are any other times, please let us know: _____

CGM Brand/Model: Meter Only:	Viewed on (receiver/phone):
Low Alarm:	High Alarm:

Insulin Administration:

Administers insulin with:	Insulin Pump/Model:
Half or whole units:	Is the pump a hybrid closed loop Yes/No:

Carb/Correction Regimen:

Breakfast carb ratio:	Carb Ratio AM Snack:	Target Blood Sugar:	Correction factor:
Lunch carb ratio:	Carb Ratio PM Snack:	Target Blood Sugar:	Correction factor:
Dinner carb ratio:		Target Blood Sugar:	Correction factor:

Fixed Dose Regimen:

Fixed Dose for Breakfast:	Fixed Dose for Lunch:
Fixed Dose for AM or PM Snack:	Fixed Dose for Dinner:

If On Sliding Scale: Is it used for **meals**, **meals & snacks** or just for **high blood sugars** (correction)

70 to 150 mg/dL = _____ units
150 to _____ mg/dL = _____ units
_____ to _____ mg/dL = _____ units

Other Diabetes Medications: If taking any other medications please list the name, doses and times taken
Ex: Metformin 1000 mg BID with breakfast and dinner: _____

Exercise related management: _____
(Ex. Pre-exercise snacks, increased monitoring, changes to regimen CR/CF or change mode in pump)

Anything else you would like to add to the school form:

_____