

School Year
20__ - 20__

TENNESSEE STUDENT HEALTH INFORMATION PLAN DIABETES

Page 1 to be
completed
by
Parent/Guardian
Please Print

Child Information

School or Community Program: _____

Name of Child: _____ Date of Birth: _____

Grade / Child's Age: _____ Homeroom Teacher or Instructor: _____

Emergency Information

Parent(s) or Guardian(s) Names: _____

Mother's Telephone (W): _____ Father's Telephone (W): _____

Pager: _____ Pager: _____

Telephone (H): _____ Telephone (H): _____

Specialist: _____ Telephone: _____

Primary Care Physician: _____ Telephone: _____

In the event a parent/guardian cannot be reached:

1. _____ Relation: _____ Telephone: _____

2. _____ Relation: _____ Telephone: _____

Preferred Local Emergency Department

My child has the following other chronic illnesses/disabilities: _____

Allergies:

Child's Limitations or Special Considerations:

Dietary and activity/exercise routines and schedules are as important as medications in the management of blood sugar (BG) in children with diabetes.

DAILY MANAGEMENT/ SCHEDULE

	AM	Mid-morning	Lunch	Mid-afternoon	Home
Blood Glucose Measurement Schedule					
Insulin Injection (Time/Dosage/Type)					
Carbohydrate grams or describe					

	Day Of Week	Time	Snack If Necessary	Other Instructions
Physical Education				
Recess				

ALL OTHER MEDICATIONS

Name of Medication	Dosage and Strength	Purpose	Day Schedule	Time of Day

Diabetics can have extremes of high and low blood sugar. Please check box of the symptoms that occur in your child.

Is your child able to recognize symptoms of high and low blood sugar? yes no

Signs and symptoms of Low Blood Sugar:

_____ Shakiness, nervousness _____ Speech difficulty _____ Headache _____ Mood changes; irritability, crying, confusion

_____ Nausea _____ Fatigue _____ Dizziness _____ Blurred vision _____ Unusual paleness; moist, clammy skin; cold sweat

Other: _____

Signs and symptoms of High Blood Sugar:

_____ Frequent thirst _____ Frequent urination _____ Mood changes; irritability, crying, confusion, inappropriate responses

_____ Nausea _____ Fatigue

Other: _____

I understand that it is my responsibility to keep this information current. Please notify School Nurse and provide an updated/current form on at least an annual basis.

Parent's/Guardian's Signature: _____

Date: _____

