H. Serv.

CHICAGO PUBLIC SCHOOLS

PHYSICIAN'S REPORT ON CHILD WITH DIABETES

(LAST NAME) (FIRST) (MIDDLE) (DOB) (ID #)

(HOME ADDRESS) (ZIP CODE) (TELEPHONE)

(PARENT'S/ GUARDIAN'S NAME) TELEPHONE SCHOOL

Dear Doctor,
The School Nurse of Chicago Public Schools is requesting your cooperation in completing the following questions. Please return this form to the above child's school and retain a duplicate copy for your files. _____
School Nurse

Blood Glucose Monitoring

Student diagnosed with □ Diabetes Type 1 □ Diabetes Type 2 on _____ (Date).

Target blood glucose _____ mg/dl Usual Time (s) to check blood glucose _____

Times to do extra blood glucose checks (*check all that apply*)
□ Before exercise □ After exercise □ When student exhibits symptoms of hyper/hypo glycemia

Student can perform own glucose checks □ Yes □ No Type of meter used _____

Insulin / Oral Medication Requirements

Oral Medications used to manage Diabetes □ Yes □ No Type _____ at _____ (Time)

Insulin is used to manage Diabetes □ Yes □ No Type _____ Units at _____ (Time)

Student requires Insulin on Sliding Scale □ Yes □ No Type of Insulin _____

Student can give own injections □ Yes □ No _____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl
_____ units if blood glucose is _____ to _____ mg/dl

For Students With Insulin Pumps Only: _____ units if blood glucose is _____ to _____ mg/dl

Insulin Pump used to manage Diabetes □ Yes □ No Type of Pump _____

Student independent in Insulin pump management □ Yes □ No

Basal Rates: ____ (rate) 12am to ____ (time), ____ (rate) ____ (time) to ____ (time), ____ (rate) ____ (time) to ____ (time), ____ (rate) ____ (time) to ____ (time)

Insulin / Carbohydrate ratio: _____ Correction factor: _____

Meals and Snacks

Carbohydrate calculations required for management □ Yes □ No Student is independent □Yes □ No

TIME	*FOOD CONTENT / AMOUNT*	*TIME*	*FOOD CONTENT / AMOUNT*
Breakfast		Mid-Morning	
Lunch		Mid-Afternoon	

Restrictions on activity, if any: _____

Field trip recommendations, if any _____

Physician's Name _____ (Please print or type) **Hospital Affiliation** _____

Address _____ **Telephone #** _____ **Fax#** _____

Physician's Signature _____ **Date** _____