YOUNG SCHOLARS OF WESTERN PENNSYLVANIA CHARTER SCHOOL
DIABETIC CHECKLIST

1. Name of student_____Grade_____Teacher _____

2. Type of diabetes: _____

3. Physician treating the child's diabetes:_____Phone : _____

4. Insulin: Type_____Amount_____Time(s) given _____

   Type_____Amount_____Time(s) given _____

5. Is blood sugar testing to be done at school? Yes_____ No _____

   Time(s) to be tested _____

   May we test your child at other times? Yes_____ No _____

   Is your child able to do the blood sugar testing without help? Yes_____ No _____

6. Are ketones to be tested in school? Yes_____ No _____

   Time(s) to be tested _____

   Is your child able to test ketones without help? Yes_____ No _____

7. Will insulin and syringes be kept at school? Yes_____ No _____
   - **All medications** kept at school require medication forms signed by your child's physician and a parent/guardian.
   - **Medication must be provided** by the parent/guardian.

8. Is your child able to draw up and self-administer insulin? Yes____ No _____

9. Does your child require a snack? Yes_____ No _____

   What time(s) should a snack be eaten? _____

   Where do you prefer snacks be eaten? Classroom_____ Office _____

10. What are your child's special dietary needs? _____

11. What are your child's symptoms of high blood sugar? _____
    What treatment is needed? _____

12. What are your child's symptoms of low blood sugar?_____What treatment is needed? _____

Other comments: _____

SIGNATURE_____DATE_____