

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

_____ units if blood glucose is _____ to _____ mg/dl

For Students With Insulin Pumps Only:

 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 _____ Hospital Affiliation _____
(Please print or type)

Address _____ Telephone # _____ Fax# _____

Physician's Signature _____ Date _____