

Bethel Health Assessment



Student Name _____ School _____

Date of Birth _____ Date _____ Grade _____

DIABETES ASSESSMENT

You have checked on school records that this student has **diabetes**. It is important to have current health information & direction when she/he needs help at school. Please complete this form & return it to your child's school so that appropriate instructions may be given to school personnel. Please contact your school nurse.

CHECK SYMPTOMS USUALLY PRESENT IN THIS STUDENT'S LOW BLOOD SUGAR REACTIONS:

___Mood changes (circle the usual): irritability crying confusion inappropriate responses
___Headache ___unusually pale, moist, clammy skin ___shaky,nervous ___dizziness
___blurred vision ___Numbness, tingling lips/tongue ___drowsiness,fatigue ___loss of consciousness
___Other _____

How often does a low blood sugar reaction occur? _____

Most recent hospitalization/emergency room visit for diabetes? _____

Diabetes is currently being treated by Dr. _____ Phone _____

List measures needed at school to help prevent a hypoglycemic reaction. (include directions for meals and snacks at school.) _____

Do blood sugar tests need to be done at school? ___No ___Yes (When? _____) Does

the child need assistance with blood sugar test? ___No ___Yes Diabetes management? _____No ___Yes

Will insulin be taken at school? ___No ___Yes ___Pen ___Shot ___Pump (type) _____

If ordered, will glucagon be provided to the school for severe hypoglycemia? ___No ___Yes

Does your child ride the school bus? ___No ___Yes Does your child participate in school sports? ___No ___Yes

THE USUAL PLAN AT SCHOOL FOR A STUDENT HAVING LOW BLOOD SUGAR PROBLEM

IS: Precautions taken:

1. If unsure whether problem is low blood sugar or high blood sugar, it is assumed to be low blood sugar and treated accordingly. Check blood sugar if possible.
2. Never attempt to give food or liquid to a student who is unconscious or having a seizure.

Action taken:

1. If conscious, give one of the following: 1/2 cup juice, 4 round glucose tabs, glucose gel, or other fast acting sugar supplied by parent. Do not leave student alone.
2. If symptoms do not improve in 15 minutes repeat the above.
3. If symptoms don't improve after second feeding repeat sugar treatment, call parent, continue to monitor
4. After symptoms subside check student care plan to see if extra snack is needed.

Emergency action:

1. If student becomes unconscious, has a seizure or is unable to swallow, call 911. If glucagon kit provided, a trained staff person should give.
2. Notify parents at once if 911 is called

Continue to the back of this sheet

Bethel Health Assessment



Student Name _____

Parent/Guardian Contact #1

Emergency Contact #2

Emergency Contact #3

Name _____

Name _____

Name _____

Relationship _____

Relationship _____

Relationship _____

Phone: _____

Phone: _____

Phone: _____

Work # _____

Work # _____

Work # _____

AMBULANCE PERMIT

I give consent for the school principal, school nurse, or other school personnel to use their judgment in securing further medical aid and to call an ambulance to take my (son, daughter)

_____ to _____ Hospital in case parent/legal guardian cannot be reached.

The above information may be shared with ambulance personnel. **PERMISSION:** YES NO

To provide for your child's safety and educational experience the above information will be shared with school staff, included in your child's school health record and may be shared electronically.

Signature of Parent/Guardian

Date (Valid One Year)

RETURN THIS FORM TO THE SCHOOL
(For Staff use only below this line)

DATE

SIGN / INITIAL

STUDENT COMPUTER SYSTEM ENTRY _____

INFORMATION SHARED WITH STAFF _____

Additional notes: _____

