Coatesville Area School District
Parent/Guardian Questionnaire for Students with Diabetes

Student Name_____School_____

School Year _____ Grade _____ Date _____

Dear Parent/Guardian,

You noted on the emergency card that your child has diabetes. In order to give the appropriate care, we request that you complete this form and return it to the school nurse immediately. This information will be used to develop an individual action plan for your child.

If there is any change in this information during the school year, please notify the school nurse in writing.

Thank you,

Certified School Nurse

Symptoms student experiences with low blood sugar. (please check all that apply)

___Headache ___Sleepiness
___Hunger ___Inability to concentrate
___Irritability ___Thickened speech
___Weakness ___Sweating
___Shakiness/trembling ___Personality changes ___Poor coordination ___Other

2. Type of Diabetes: Type I_____ Type II_____

3. Medications needed:
Name _____
Dose _____ Time _____

Name _____
Dose _____ Time _____

4. BGL Monitoring: Times_____ Acceptable range _____

5. Special Instructions_____

Name of Physician _____ Phone Number_____

I understand the above information will be used in an emergency action plan for my child. I give my permission to share this plan with my child's assigned teachers and appropriate personnel.
Signature of Parent/Guardian_____ Date_____