NWCA Head Start/Early Head Start
312 N. Main P.O. Box 67 Badger, MN 56714
218-528-3227 800-568-5319

Diabetes Record

Last Name	First	Middle	Birth Date

Physician treating child's diabetes: Name_____Phone_____

1. When was your child first diagnosed with diabetes? Date or age

2. Is your child **Insulin** dependent? ☐ yes ☐ no

   Your child's current dosage:

   Insulin type: _____ Dosage:_____
   Insulin type: _____ Dosage:_____

   Time of day: _____ Site:_____

3. Does your child need his/her **Blood Glucose** checked at school? ☐ yes ☐ no

   Acceptable range of Blood Glucose:_____

   Time of day Blood Glucose needs to be checked:_____

4. Is any medication or insulin needed during school time? ☐ yes ☐ no

5. Does your child need specific meal time and/or snack time? ☐ yes ☐ no

   Time of day:_____
   Food:_____
   Amount:_____

6. What needs to be done if your child does not eat the entire meal/snack?

7. What are your child's signs and symptoms of Ketoacidosis (**high blood sugar**)?

- Does your child recognize the signs and symptoms? ☐ yes ☐ no
- Does your child know to request treatment? ☐ yes ☐ no
- What treatment is needed?

8. What are your child's signs and symptoms of **Insulin reaction**?

- Does your child recognize the signs and symptoms? ☐ yes ☐ no
- Does your child know to request treatment? ☐ yes ☐ no
- What treatment is needed?

9. What are your child's signs and symptoms of **low blood sugar**?

- Does your child recognize the signs and symptoms? ☐ yes ☐ no
- Does your child know to request treatment? ☐ yes ☐ no
- What treatment is needed?

10. What, if any, special instructions do you have if your child has any other diabetes related incidents?

Other comments:

Parent
Signature_____Date_____