School District of the City of Niagara Falls
Department of Health Services
DIABETES: HEALTH CARE PROVIDER FORM

Date________ Name____ Date of Birth__________________
School____________________________________ __________________ Grade______________________
School Nurse____Health Office Phone____________

To Be Completed by Parent/Guardian

In order to provide your child with the safest environment for learning, New York State Education Department requires that all students who have ongoing chronic illnesses provide yearly medical updates to your child's School Health Services. **Please return this form with all appropriate supplies to the School Nurse on the 1st day of student's return to school.**

Parent Signature Required:

I hereby grant permission for the medical staff of the Niagara Falls City School District to obtain all medical information from my child's health care provider(s) pertaining to Diabetes and any other medical problems that may be associated with this disease. **I authorize the Health Office to share this information with school personnel as needed.**

X ____
Signature of Parent/Guardian

____
Date

I hereby grant permission for my child to receive the medication(s), perform blood testing and urine testing as prescribed in column two by our health care provider, and in any crisis or emergency situation. I will provide the Niagara Falls City School District with the properly labeled prescribed medication(s) (original container, Pharmacy labeled) and equipment.

X ____
Signature of Parent/Guardian

____
Date

EMERGENCY PHONE No.

____
Home

____
Work

____
Others

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Type of Diabetes__________________________________
Medication/Insulin:________________________________
Carb Counting: For ____________________Grams of Carbs
Give _______ units_____________________________ insulin
Insulin Pump Yes________ No__________
Basal Rate__________units/hour______________________
Correction Calculations: ___________________________
____

Test *BLOOD SUGARS* at school at the following times: Check all that apply:

	Before	After
Breakfast	_____	____
Lunch	_____	____
Sports	_____	_____
Physical ED.	_____	_____

Other______________________________________

Permission to test when symptoms of hypoglycemia or hyperglycemia appear. Yes_____ No______

Test *URINE* at school at the following times:

____________AM _____________PM _________Other

Urine should be tested for ketones if blood sugar is over____________.

If urine is positive for ketones administer __________ units of ______________ insulin.

Retest blood sugar_________________________________
Retest urine for ketones_____________________________

Glucagon tablets_______ injection_____ Glucose gel____
Should be administered______________________________

Snacks should be eaten_____________________________

May participate in Physical Education Program without restrictions: GYM YES____ NO___
POOL YES____ NO___
If no, list restrictions/comments________________________
____
Duration of restrictions: From_____________to___________

This student is a well controlled, self-directed Diabetic, understands his/her disease and may participate in **Interscholastic/Modified Sports Program** without restrictions: YES_________ NO_________

If restrictions, please clarify___________________________
Other Comments___________________________________
____

________________________________ ____________
Health Care Provider Date

____________________ ____________________
Phone Stamp

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