Office of Special Education & Supports · 125 South Clark Street, Suite 800 · Chicago, Illinois 60603 • Telephone: 773-553-1800

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PHYSICIAN'S REPORT ON A CHILD WITH DIABETES

Student Name	Student ID#	Date of Birth	Student Grade

Home Address (City, State, Zip Code) _____ Parent/Guardian Name _____

Parent/Guardian Home Phone # _____ Alternate # (Work or Phone) _____

School Name	School's Address	School's Fax Number

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.

_____
Signature of School Nurse

BLOOD GLUCOSE MONITORING

Student diagnosed with:

☐ Diabetes Type1 ☐ Diabetes Type 2 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/hypoglycemia

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_____

_____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

ADMINISTRATION OF INSULIN

Student can self-administer insulin injections ☐ Yes ☐ No

Student must be supervised when administering insulin injections ☐ Yes ☐ No

Adult must administer insulin injections ☐ Yes ☐ No

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For Students with Insulin Pumps Only:

Insulin Pump used to Manage Diabetes ☐ Yes ☐ No

Student Independent in Insulin pump management ☐ Yes ☐ No

Basal Rates:_____ 12 am 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:_____

_____

_____

_____

Physician's Name_____ **Hospital Affiliation**_____

Address_____**Telephone#**_____**Fax#**_____

Physician Signature_____ **Date**_____

Parent/Guardian Signature_____ **Date**_____

*This request is valid for 1 year from date of signature. Any medication change or dose requires a new request form.

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