

DIABETES HEALTH HISTORY FORM and MANAGEMENT PLANNING TOOL

The purpose of this form is to aid the school nurse in gathering the information necessary to develop the student's Individualized Health Plan and Emergency Action Plan.

Effective Dates: _____

Student Name _____ **Date of Birth** _____

Grade: _____ **Homeroom Teacher:** _____

Known Allergies: _____

Diagnosis: ☐ diabetes type 1 ☐ diabetes type 2 **Date of diabetes diagnosis:** _____

Last hospitalization/ER visit for diabetes: _____ **Has glucagon ever been administered? (Y/N)** _____

CONTACT INFORMATION

Mother/Guardian _____

Phone #s: Home _____ Cell _____ Work _____

Father/Guardian _____

Phone #s: Home _____ Cell _____ Work _____

Student's Doctor/Health Care Provider

Name: _____

Address: _____

Phone # _____ **Emergency Number:** _____

Preferred Hospital _____

Emergency Contact:

If parent cannot be contacted in case of emergency, please contact the following person:

Name _____

Relation to child/family _____

Phone #s: Home _____ Cell _____ Work _____

In the event that your child has an accident or becomes ill at school, please list the physician to be called. All reasonable efforts will be made to contact you first!

Notes: Notify parents/guardian or emergency contact in the following situations:
