In the Absence of the Health Center Nurse:

qualified substitute nurse and the parents are not available, the parent will designate a

Nurse QUICK-LOOK Form

Name ______________________ Grade/ Teacher ________________ School Year_________

Uses: Pump / Syringe / Pen Pump/Pen Name_____________ Meter Name _______________
Student can: do BG test - Yes / No administer insulin - Yes / No carry insulin/supplies- Yes / No

Blood Glucose Target Range: ________ to ________

If administering Insulin per pump, please refer to pump settings/instructions/parent for directions.

If administering Insulin per injection, Carb/Insulin Ratio: ____:_____

Time: ______ BG Testing before lunch. If BG is _____ or higher, he/she is ok to go eat lunch. If lower than 80, please see below.* Student Will / Will Not pre-bolus before lunch.
Special Notes: ____

Time: __________ He/She will return after lunch for insulin correction, given SQ/ thru the pump. Calculate

Deer Valley Unified School District

Diabetic Supply Checklist

Student Name ____________________________ School ________________________

Grade/Teacher ____________________________ School Year____________________

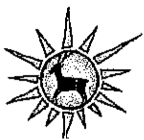
1. Diabetes Treatment Plan for School
   From Physician/Endocrinologist
   From Nurse

2. Diabetes Questionnaire

3. Diabetes Self-Management Authorization

4. Supplies for School (circle supplies to be used for this student)
   Blood Glucose Meter, blood glucose test strips and batteries (Please supply 2 meters, 1 for class/ 1 for Health Office)

   Insulin Pump supplies, extra sites, batteries
   Insulin vials and syringes
   Urine / blood ketone strips
   Quick Carb resources (glucose tabs, sweet tarts, fruit chews, cake icing)
   Snacks, protein snacks (cheese & crackers, string cheese, beef jerky)



HS P-1

Student: ______________________ DOB: ______________

Grade/Teacher: ______________ School: ______________