Abington Heights School District
Clarks Summit, PA 18411

PARENT REQUEST FOR DIABETIC MANAGEMENT IN SCHOOL

Student Name_____

Student Date of Birth:_____ Grade:_____

Blood Sugar Testing Times: _____

_____

Blood Sugar Range:_____

Hypoglycemia Instructions:_____

Glucagon: Yes____ No_____

Directions:_____

Insulin:_____

Hyperglycemia Instructions:_____

Is student capable of self-administration supervised by a responsible adult if the nurse is not in the school? ☐ Yes ☐ No (Check one)

Other medications taken by student_____

_____

_____	_____	_____
Date	Parent's Signature	Telephone

Revised 05/06/04