



School Health Program

Student Diabetes Checklist

Student Name: _____ **DOB:** _____

School Nurse: _____ **Date:** _____

The student has demonstrated understanding and competency consistently:

SKILLS	YES	NO	COMMENTS
States signs and symptoms of hypoglycemia (low blood sugar)			
States appropriate treatments of low blood sugar			
States signs and symptoms of hyperglycemia (high blood sugar)			
States appropriate treatments of high blood sugar			
Knows how to test/monitor blood sugar			
Knows when snack is needed			
Knows when to administer medication			
States need to call 911			

The student agrees to follow the safety precautions with medication compliancy and to report any discomfort or distress.

Student Signature _____ Date: _____

Parent Name/Signature _____ Date _____

I hereby acknowledge that the student listed above has demonstrated all the above listed skills.

School Nurse Signature _____ Date _____

Review Dates: _____