CITY OF BLOOMINGTON MINNESOTA
PARKS AND RECREATION

DIABETES FORM

To be filled out by Parent or Guardian

CONFIDENTIAL

HH #: _____

Forms that were completed for your child's current school year with a physician signature may be submitted in addition to this form, and the physician signature on that form can be used in place of this form.

Completion of this form is required along with a parent or guardian signature

The City of Bloomington, Parks and Recreation intends to use the requested information to provide for your child's health and safety while at programming. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health plan for your child. The information you provide will be shared only with staff in the program whose jobs require access to this information to ensure your child's safety.

Effective Year: _____

PARTICIPANT

FIRST NAME:	**LAST NAME:**
BIRTH DATE:	☐ **Male** ☐ **Female**
HOME PHONE:	**CELL #:**
DATE OF DIABIETES DIAGNOSIS	**EFFECTIVE DATES**
PHYSICAL CONDITION: ☐ Diabetes type 1 ☐ Diabetes type 2	**Are levels currently at a controlled level?** ☐ Yes ☐ No

DIABETIC

BLOOD GLUCOSE MONITORING

Target range for blood glucose is:		70-150		70-180	Other:
Usual times to check blood glucose:					
Times to do extra blood glucose checks (*check all that apply*)		Before exercise		After exercise	
		when participant exhibits symptoms of hyperglycemia			
		when participant exhibits symptoms of hypoglycemia			
		Other: (explain)			
Can participant perform own blood glucose checks?				Yes	No

Exceptions:

Type of blood glucose meter participant uses:

INSULIN

- Base dose insulin at lunch is _____ units
- Flexible dosing using _____ units/ _____ grams carbohydrate
- Use of other insulin at lunch: _____ units or basal/Lantus/Ultralente _____ units.
- Other info: (please list)

INSULIN CORRECTION DOSES

	Units if blood glucose is		to		mg/dl	Can participant give own injections? ☐ Yes ☐ No
	Units if blood glucose is		to		mg/dl	Can participant determine correct amount of insulin?
	Units if blood glucose is		to		mg/dl	☐ Yes ☐ No
	Units if blood glucose is		to		mg/dl	Can participant draw correct dose of insulin?
	Units if blood glucose is		to		mg/dl	☐ Yes ☐ No

Parental authorization should be obtained before administering a correction dose for high blood glucose levels ☐ Yes ☐ No

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DIABETES FORM CONTINUED

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DIABETIC

For Participants with Insulin Pumps

Type of pump:		12 am to	
Basal rates:		to	
		to	

Type of insulin in pump:

Type of infusion set:

Insulin/carbohydrate ratio: **Correction factor:**

DIABETIC Continued

Participant Pump Abilities/Skills:	**Needs Assistance**			
Count carbohydrates		**Yes**		**No**
Bolus correct amount for carbohydrates consumed		**Yes**		**No**
Calculate and administer corrective bolus		**Yes**		**No**
Calculate and set basal profiles		**Yes**		**No**
Calculate and set temporary basal rate		**Yes**		**No**
Disconnect pump		**Yes**		**No**
Reconnect pump at infusion set		**Yes**		**No**
Prepare reservoir and tubing		**Yes**		**No**
Insert infusion set		**Yes**		**No**
Troubleshoot alarms and malfunctions		**Yes**		**No**

For participants taking oral diabetes medications*

Type of medication: **Timing:**

Other medications: **Timing:**

Meals and snacks eaten at program

Is participant independent in carbohydrate calculations and management? ☐ **Yes** ☐ **No**

Meal/Snack	*Time*	***Food content/amount***
Breakfast		
Mid-morning snack		
Lunch		
Mid-afternoon snack		
Dinner		

Snack before exercise? ☐ **Yes** ☐ **No** Snack after exercise? ☐ Yes ☐ No

DIABETIC

*** Complete Medication form in addition to this form**

CITY OF BLOOMINGTON MINNESOTA PARKS AND RECREATION

DIABETES FORM CONTINUED

CONFIDENTIAL

DIABETIC

DIABETIC Continued

DIABETIC

Meals and snacks eaten at program continued

Other times to give snacks and content/amount:
(snacks must be provided by parent/guardian)

Preferred snack foods:

Foods to avoid, if any:

Instructions for when food is provided to the program :
(i.e. program party, food sampling, etc.):

Exercise and Sports

A fast-acting carbohydrate such as _____ should be available at the site of exercise or sports.

Restrictions on activity, if any: _____ participant should not exercise if blood glucose level is below _____ mg/dl or above _____ mg/dl.

Hypoglycemia (Low Blood Sugar)

Participant usual symptoms of hypoglycemia:

Treatment of hypoglycemia:

Glucagon should be given if the participant is unconscious, having a seizure (convulsion), or unable to swallow.

Route _____ Dosage _____

Site for glucagon injection: ☐ arm ☐ thigh or ☐ other _____

If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance) and the parent/guardian.

Hyperglycemia (High Blood Sugar)

Participant usual symptoms of hyperglycemia:

Treatment of hyperglycemia:

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DIABETES FORM CONTINUED

CONFIDENTIAL

DIABETIC Continued

Supplies kept at program:

	Blood glucose meter, blood glucose test strips, batteries for meter		Insulin pen, pen needles, insulin cartridges
	Lancet device, lancets, gloves, etc.		Fast-acting source of glucose
	Insulin pump and supplies		Carbohydrate containing snack
	Other (please list):		Glucagon emergency kit

Forms that were completed for your child's current school year with a physician signature may be submitted in addition to this form, and the physician signature on that form can be used in place of this form.
Completion of this form is required along with a parent or guardian signature

RETURN TO: City of Bloomington, Parks & Recreation, 1800 W. Old Shakopee Rd, Bloomington, MN 55431

Please do not forget the necessary signatures below.

Physician Signature (required): **Date:**

Form Completed by:

Relationship to Participant:

Date: **Phone:**

The Data Practices Act requires that we inform you or your rights about the private data we are requesting on this form. Private data is available to you, but not to the public. This information can be shared with the Bloomington Parks and Recreation staff. You can withhold this data, but you may not receive updated program information and/or accommodations. Your signature on this form indicates you understand these rights.

Signature of legal guardian REQUIRED

SIGNATURE: _____ **DATE:** _____

OFFICE ONLY:
Received on _____ (date) by _____(Staff)
RecTrac updated? Y / N
Plan Created? Y / N
Parent/Guardian contacted? Y / N
P/G contacted on _____ (date)

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