

**BABOQUIVARI UNIFIED SCHOOL DISTRICT #40**

**DIABETES HISTORY**

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Name of Student

Date of Birth

1. What type of diabetes does your student have?  
Type I \_\_\_\_\_ Type II \_\_\_\_\_
  
2. At what age were they diagnosed with diabetes? \_\_\_\_\_
  
3. Does your student take oral medications for diabetes? Please list the name(s) of medication, dosage and how often your student takes their medication(s).  
  
\_\_\_\_\_
  
4. Does your student take insulin for diabetes? Y N
  
5. If your student takes insulin, how is it given (i.e. syringe, insulin pen, insulin pump)?  
  
\_\_\_\_\_
  
6. Are any of your student's medications taken during school hours Y N If yes, a **Consent to Administer Medication** form must be completed. If your student will self-administer insulin, a **Consent to Self-Administer Medication** must be completed.
  
7. Will your student be eating breakfast and/or lunch at school? Y N
  
8. Will your student be riding the bus? Y N If yes, your student's bus driver will be informed that your student is diabetic.
  
9. Does your student play sports? Y N If yes, your student's coach(es) will be informed that your student is diabetic.

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Signature of Parent/Guardian

Date