NORTHERN TERRITORY GOVERNMENT

DEPARTMENT OF EDUCATION

DIABETIC CLIENT INFORMATION

Student's Name:		Photo
Date of Birth:	School:	
Male ☐ Female ☐	Class:	
Name of Parent / Guardian:		
Address:		
Telephone (Work):	Telephone (Home):	
Name of Doctor / Surgery:		
Telephone (Surgery):	Type of Diabetes:	

Is your child's diabetes stable or unstable?

Are there any limitations on participation in any school activities? Yes ☐ No ☐
If YES, please give details (including additional supervision required):

Are hypo/hyperglycaemia attacks likely to occur at school?
Yes ☐ No☐

If your child has a hypo/hyperglycaemia attacks at school, what is their Emergency Plan and what should school staff do? Please describe the procedure in detail:

Does your child monitor their blood glucose levels at school? Yes ☐ No☐
If so, how often and when?

Does your child self-administer insulin or any other medication at school? Yes ☐ No☐
If yes please complete the area immediately below this.

Medication Name	Dosage	Frequency	Side effects

Comments / further information:

Signature of Parent / Guardian:	**Date:**