DIABETES MEDICAL REQUEST TO PROVIDER (DM-DMR)

Student: _____ **Student ID #:** _____ **DOB:**_____
School: _____ **Parent/Guardian:** _____ **Phone:** _____
Dear Health Care Provider, _____ was seen in the school health office for problems
(name of student)
with his/her diabetes. The following is a brief summary of school observations:

Presenting symptoms:
- ☐ Low blood glucose symptoms
- ☐ Assisted to office
- ☐ High blood glucose symptoms
- ☐ Unresponsive
- ☐ Other: _____
_____

Corresponding event:
- ☐ Too much food
- ☐ Increased activity
- ☐ Missed meal
- ☐ Missed-calculated amount of CHO.
- ☐ Missed insulin/medication dose: _____
- ☐ Took too much insulin
- ☐ Too little food
- ☐ Illness
- ☐ Other: _____

Data
☐ Blood glucose result: _____ ☐ Ketone result: _____

Medication/treatment in the health office:
- ☐ Low blood glucose treatment with, _____ gms. of carbohydrate.
- ☐ Glucagon per orders.
- ☐ Insulin: _____ units
  - ☐ via syringe ☐ via pen ☐ via pump
- ☐ Long acting insulin: _____
- ☐ Other:_____
- ☐ No medicine in health office
- ☐ No diabetes [medical] management plan in health office

Number of school absences this academic year: _____

Comments:_____
_____
_____
_____
_____
_____
_____

Other data/comments:_____
_____
_____

To support this student's diabetes management at school, please address:
- ☐ Medical evaluation of this child.
- ☐ Evaluate for change in insulin dosing.
- ☐ Current Diabetes [Medical] Management Plan signed by the health care provider (may serve as medication consent form)
- ☐ Evaluate for change in nutrition plan.
- ☐ Evaluate for change in exercise/activity regime.
- ☐ Medication for school
- ☐ Blood glucose meter for school
- ☐ Other:_____

School Nurse:_____ **Date:**_____
Phone/pager # _____ **Fax #**_____

Health Care Provider Response:
- ☐ See attached new or revised Diabetes [Medical] Management Plan
- ☐ Continue with current Diabetes [Medical] Management Plan
- ☐ Medication for use at home_____
- ☐ Medication/meter refill called to student's pharmacy.
- ☐ Other_____

Health Care Provider name/signature:_____

Clinic Phone:_____ **Date:**_____