



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 also be submitted in place of this form. ★

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:** \_\_\_\_\_

<b>PARTICIPANT</b>	<b>FIRST NAME:</b> _____	<b>LAST NAME:</b> _____
	<b>BIRTH DATE:</b> _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
	<b>HOME PHONE:</b> _____	<b>CELL #:</b> _____
	<b>DATE OF DIABETES DIAGNOSIS</b> _____	<b>EFFECTIVE DATES</b> _____
	<b>PHYSICAL CONDITION:</b> <input type="checkbox"/> Diabetes type 1 <input type="checkbox"/> Diabetes type 2	<b>Are levels currently at a controlled level?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>DIABETIC</b>	<b>BLOOD GLUCOSE MONITORING</b>		
	<b>Target range for blood glucose is:</b>	70-150	70-180
	<b>Usual times to check blood glucose:</b>	Before exercise	After exercise
	<b>Times to do extra blood glucose checks</b> (check all that apply)	when participant exhibits symptoms of hyperglycemia	
		when participant exhibits symptoms of hypoglycemia	
		Other: (explain) _____	
<b>Can participant perform own blood glucose checks?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Exceptions: _____			
<b>Type of blood glucose meter participant uses:</b> _____			

<b>DIABETIC</b>	<b>INSULIN</b>		
	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) _____			

<b>DIABETIC</b>	<b>INSULIN CORRECTION DOSES</b>					
	Units if blood glucose is	_____	to	_____	mg/dl	Can participant give own injections? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Units if blood glucose is	_____	to	_____	mg/dl	Can participant determine correct amount of insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Units if blood glucose is	_____	to	_____	mg/dl	
	Units if blood glucose is	_____	to	_____	mg/dl	Can participant draw correct dose of insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No
Units if blood glucose is	_____	to	_____	mg/dl	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

**DIABETIC**
**For Participants with Insulin Pumps**

<b>Type of pump:</b>		12 am to	
	<b>Basal rates:</b>		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

**DIABETIC**

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

\* Complete Medication form in addition to this form

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.):

DIABETIC Continued

## 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.

DIABETIC

## Hyperglycemia (High Blood Sugar)

Participant usual symptoms of hyperglycemia:

Treatment of hyperglycemia:

<b>DIABETIC Continued</b>	<b>Supplies kept at program:</b>	
	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

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**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)

<b>Community Services Department</b>	Parks and Recreation Division 1800 W. Old Shakopee Road Bloomington, MN 55431-3027	PH 952-563-8877 FAX 952-563-8715 TTY 952-563-8740	parksrec@ci.bloomington.mn.us www.ci.bloomington.mn.us
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The City of Bloomington does not discriminate on the basis of disability in the admission or access to, or treatment or employment in, its services, programs, or activities. Upon request, accommodation will be provided to allow individuals with disabilities to participate in all City of Bloomington services, programs, and activities. Upon request, this information can be available in Braille, large print, audio tape and/or computer disk.