FRIENDS FOR LIFE®

international children with diabetes conference orlando 2015

Childcare Medical Information Sheet

Please complete one form for each of your children with type 1 diabetes or any other medical concern of which we need to be aware. This will be used in conjunction with the childcare registration form you completed. **Mail, fax, or scan/email this form, no later than June 1, 2015, to the attention of: Mary Bulgarelli, 94 Autumn Woods Lane, Glen Mills, PA 19382, fax 610-459-4353, email maryboogs@gmail.com.** Please be sure to complete ALL fields in order to speed up registration on the first day. Please email Mary with any questions you may have regarding completion of this form. Additional childcare details will come via email approximately two weeks before the conference. Thank You.

1. Child's name (nickname): _____

2. Age: _____

3. Parents' or Guardian's names

   Mom: _____

   Dad: _____

   Other: _____ (include relationship)

   Cell Phone (if you have one, so we can reach you directly during the sessions)

   Mom: _____

   Dad: _____

   Other: _____

4. Which would you prefer (check one):

   ❒ My child will be tested using an ACCU-CHEK® Connect meter. I understand that test results will be available to me in real time using the ACCU-CHEK® Connect mobile app.

   ❒ I will come to check my child's BG levels with his/her own meter.

5. At what time do you want your child's blood glucose level to be checked? All times are approximate. (Check all that apply)

   ❒ 9:30 am ❒ 2:30 pm
   ❒ 11:00 am ❒ 4:00 pm

Child's Name: _____

6. At what **BG levels** would you like us to contact you in a session?

   ❒ Higher than: _____ ❒ Lower than: _____

   If you would like to know your child's BG during your sessions, how would you like us to contact you?

   ❒ Call cell phone ❒ Send text message

7. How do you manage your child's diabetes? (**Childcare volunteers will <u>not</u> be administering insulin but need this information in case of an emergency.**)
   - ❒ Injections
   - ❒ Insulin Pump
   - ❒ CGM
   - ❒ Other info: _____

8. If your child has another medical condition, please advise what it is and what we need to do to assist:

_____

_____

_____

_____

_____

_____

8. How would you like a low blood sugar (70 mg/dl or lower or rapid decrease shown in CGM) treated?

   ❒ With a juice box

   ❒ With glucose tablets

9. If your child uses a CGM and it alarms during your session, would you like to be notified?

   ❒ Yes ❒ No

   If yes, please indicate how:

   ❒ Call cell phone ❒ Send text message

   Cell phone to contact: _____

Thank You!