ST. AUGUSTINE MISSION SCHOOL

Diabetes Screening Research and Fitness Nutrition Programs

Date___________________

Child's Name____

School ____ Grade___________________

Tribal Affiliation ____

Estimated Amount of ALL Indian Blood:

Full_________ ¾_____ ½_____ ¼_____ Non-Indian_________

Child's Mother has diabetes: Yes_____ No_____ Unknown_

Child's Father has diabetes: Yes_____ No_____ Unknown_

Estimated Annual Family Income (check one)

_____Less than $10,000 _______ $10,000 – 20,000 ________ $20,000 – 30,000

_____$30,000 – 40,000 _______ $40,000 – 50,000 _______ Greater than $50,000

Estimated Average Family Education Level

High school or GED ________ Some College __________

2 year College Degree ______ 2-4 year College________ Master's (+) Degree_______

Student's medical conditions

My Child has the following medical condition_______________________________________

____

My child is currently taking the following medication_________________________________

____

List any physical limitations your child may have_____________________________________

____

I give permission for my child to participate in Diabetes Risk Assessment Screening/Research and Fitness and Nutrition Programs.

______________________________________ ______________________________________

Parent/Guardian Signature Print Parent/Guardian Name

Phone/Cell #_____________________________

Revised 10/2017