DEPARTMENT OF EDUCATION

P.O. Box 83720
BOISE, IDAHO 83720-0027

SHERRI YBARRA
STATE SUPERINTENDENT
PUBLIC INSTRUCTION

Pupil Transportation Section

CERTIFICATE OF MEDICAL EXAMINATION FOR INSULIN-TREATED DIABETES MELLITUS

Physician: The applicant identified below is subject to the provisions of § 33-1509 of Idaho Code and Administrative Rules of the Idaho State Board of Education (IDAPA 08.02.02.150-190). The applicant has applied for an exemption from Idaho physical requirements (ITDM) specific to driving a school bus in the State of Idaho. Granting of such an exemption is contingent upon the applicant submitting annual and quarterly medical statements to the State Department of Education. Your cooperation in this matter is appreciated.

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Name of Applicant: _____ DOB: _____

Address of Applicant: _____
(Street) (City) (State) (ZIP)

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REPORT OF EXAMINATION AND MEDICAL HISTORY BY ENDOCRINOLOGIST

TODAY'S DATE: _____

	Description of Query and Certification	YES	NO
1	I am familiar with the applicant's medical history for the past five (5) years through actual treatment or through consultation with a physician who has treated the applicant.		
2	I have conducted a complete and thorough medical examination including a comprehensive evaluation of the applicant's medical history and current status OR I am aware of, and have access to, a report of the applicant's medical examination and comprehensive evaluation through consultation with the physician who conducted the medical examination and evaluation.		
3	The medical examination, evaluation and subsequent report include: a) the date insulin use began; b) diabetes diagnosis and disease history; c) hospitalization records; d) consultation notes for diagnostic examinations; e) special studies pertaining to the diabetes; f) all follow-up reports; g) reports of any hypoglycemic insulin reactions within the last five years; h) two (2) measures of glycosylated hemoglobin, the first ninety days before the last and current measure; i) insulin dosage and types, diet utilized for control and any significant factors such as smoking, alcohol use, and other medications or drugs taken; and j) examinations to detect any peripheral neuropathy or circulatory insufficiency of the extremities.		
	Query and Certification Continues On Next Page		

	Description of Query and Certification	YES	NO
4	The applicant has been educated in diabetes and its management, has been thoroughly informed of and understands the procedures which must be followed to monitor and manage the applicant's diabetes, understands what procedures should be followed if complications arise and has the ability to recognize the early symptoms of hypoglycemia such as sweating, anxiety, forceful heartbeat and lightheadedness.		
5	The applicant has the ability and has demonstrated a willingness to properly monitor and manage the applicant's diabetes.		
6	The applicant understands the importance of maintaining and maintains appropriate medical supplies for glucose management while preparing for the operation of a commercial motor vehicle and during its operation including: a) an acceptable glucose monitor with memory; b) supplies needed to obtain adequate blood samples and to measure blood glucose; c) Insulin to be used as necessary; and d) an amount of rapidly absorbable glucose to be used as necessary.		
7	The applicant has been educated in the procedures which must be followed to monitor and manage the applicants blood glucose levels and agrees prior to driving and while driving to: a) check glucose before starting to drive and take corrective action if necessary – if glucose is less than 100 milligrams per deciliter (mg/dl), take glucose or food and recheck in 30 minutes – do not drive if glucose is less than 100 mg/dl – and repeat the process until glucose is greater than 100 mg/dl; b) while driving check glucose every two to four hours and take appropriate action to maintain it in the range of 100 to 400 mg/dl; c) have food available at all times when driving – if glucose is less than 100 mg/dl, stop driving and eat – recheck in 30 minutes and repeat procedure until glucose is greater than 100 mg/dl; and d) if glucose is greater than 400 mg/dl, stop driving until glucose returns to the 100 to 400 mg/dl range – if more than two hours after last insulin injection and eating, take additional insulin – recheck blood glucose in 30 minutes – do not resume driving until glucose is less than 400 mg/dl.		
8	I am aware of the make and model of the glucose monitoring device with memory that is currently used by the applicant.		
9	I am aware of the applicant's blood glucose measurements and the applicant's glycosylated hemoglobin are generally in an adequate range based on daily glucose measurements taken with the glucose monitoring device and correlated with the daily records of driving time and a current measurement of glycosylated hemoglobin.		
10	The applicant has provided me with a copy of the applicant's Application for Exemption and/or Application for Exemption Renewal and I concur with the applicant's declarations regarding the applicant's ITDM status as documented in the Application for Exemption and/or Application for Exemption Renewal and the date of the Application for Exemption and/or Application for Exemption Renewal reasonably corresponds to the date of this medical certification.		
11	It is my professional opinion that the applicant has not had a recent history of a hypoglycemic reaction that resulted in any change in mental status that would have been detrimental to safe driving.		
12	It is my professional opinion that the applicant's diabetic condition will not adversely affect the applicant's ability to operate a school bus.		
	Signature and Certification On Next Page		

Physician: Please provide additional comments related to your examination of the applicant, any recommended driving restrictions, recommended Insulin-Treated Diabetes Mellitus blood-sugar monitoring sequence, etc.

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CERTIFICATION OF ENDOCRINOLOGIST

I, (*print full name*) _____, being a board-certified or board-eligible endocrinologist, certify that I have personally examined the individual named above on this date, or have consulted with the aforementioned individual's personal physician this date, and that this is a true and complete report of medical examination and comprehensive evaluation or that this is a true and complete report based on a thorough and comprehensive physician to physician consultation as documented in my professional records and according to the declarations herein made.

_____ _____

Signature of Endocrinologist *Date*

_____ _____

Phone *Street Address* *City* *State* *Zip*

PLEASE RETURN THE ABOVE COMPLETED MEDICAL REPORT & CERTIFICATION TO:

Supervisor of Transportation Services
Idaho State Department of Education
Pupil Transportation Section
P.O. Box 83720
Boise, Idaho 83720-0027