

## MEDICAL CERTIFICATE

This is to certify that

.....  
Name of patient

date of birth: .....

place of residence: .....

is an insulin dependant/non-insulin dependant diabetic.

**In order to ensure correct therapy,  
the following should be carried when travelling:**

- |   |  |
|---|--|
| <input type="checkbox"/> Insulin                            | <input type="checkbox"/> Disinfectant                  |
| <input type="checkbox"/> Insulin (hypodermic syringes)      | <input type="checkbox"/> Urin glucose test strips      |
| <input type="checkbox"/> Insulin pump with accessories      | <input type="checkbox"/> Blood glucose test strips     |
| <input type="checkbox"/> Insulated cooling pack for insulin | <input type="checkbox"/> Blood glucose meter           |
| <input type="checkbox"/> Tablets                            | <input type="checkbox"/> Lancets                       |
| <input type="checkbox"/> Glucagon syringe                   | <input type="checkbox"/> Dextrose                      |
| <input type="checkbox"/> Cotton balls                       | <input type="checkbox"/> Diet/diabetic food provisions |

.....  
Date

.....  
Doctor's signature and stamp

