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DIABETES PARENT QUESTIONNAIRE

Student Name: _____DOB: _____
Grade/Teacher:_____

Please complete and return to the school nurse. The following information is helpful in helping maintain optimal diabetes management.

Healthcare Provider _____Clinic _____Phone_____

Hospital of preference_____

1. Student's age at diagnosis of diabetes: _____ Most recent A1C_____
2. Does this student wear a medical alert bracelet/necklace? ☐ Yes ☐ No
3. Have you attended Diabetes Education classes? ☐ Yes ☐ No
4. Will this student need routine snacks at school? ☐ AM ☐ PM _____ as needed
   (snacks will need to be provided by the family)
5. What would you like done about birthday treats and/or party snacks? _____
6. Will your child participate in the school lunch program? ☐ Yes ☐ No ☐ Occasionally
7. Does this student know how to test his/her own blood sugar? ☐ Yes ☐ No
8. Will this student need to test his/her urine for ketones at school? ☐ Yes ☐ No
9. Will this student need to test his/her blood for ketones at school? ☐ Yes ☐ No
10. What blood sugar level is considered low for this student? Below _____
11. How often does this student typically experience low blood sugar? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____
12. When does this student typically experience low blood sugar?
    ☐ mid AM ☐ Before lunch ☐ Afternoon ☐ After exercise ☐ Other
13. Please check your student's usual signs/symptoms of low blood sugar.

☐ hunger or "butterfly feeling"	☐ irritable	☐ difficulty with speech
☐ shaky / trembling	☐ impaired vision	☐ difficulty with coordination
☐ dizzy	☐ weak / drowsy	☐ confused / disoriented
☐ sweaty	☐ inappropriate crying / laughing	☐ loss of consciousness
☐ rapid heartbeat	☐ severe headache	☐ seizure activity
☐ pale	☐ anxious	☐ other _____

14. In the past year, how often has this student been treated for severe low blood sugar?
    ☐ In a health care providers' office_____ ☐ in the emergency room_____ ☐ Overnight in the hospital_____
15. Please check your student's usual signs/symptoms of high blood sugar:
    ☐ thirst ☐ blurred vision ☐ frequent urination ☐ drowsiness
    ☐ fatigue ☐ nausea/vomiting ☐ dry skin ☐ behavior changes ☐ Other_____
16. In the past year, how often has this student been treated for severe high blood sugar or diabetic ketoacidosis?
    ☐ In a health care providers' office_____ ☐ in the emergency room_____ ☐ Overnight in the hospital_____
17. Does he/she recognize signs/symptoms of low blood glucose? ☐ Yes ☐ No
    High blood glucose? ☐ Yes ☐ No

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Please indicate your child's skill level for the following

Skill	Does alone	Does with help	Done by adult	Comments
Pokes blood glucose site				
Reads meter and records				
Counts carbs for meals/snack				
Can interpret sliding scale				
Selects insulin injection site				
Measures insulin				
Administers insulin				
Measures ketones				
Pump skills				

Medication taken on a regular basis

Name _____ By (mouth, injection etc) _____ Dose _____ Time of day _____

_____ _____ _____ _____

Insulin taken on a regular basis

Name _____ Type _____ Units _____ Time of Day _____ Delivery method (Pen/syringe/pump) _____

_____ _____ _____ _____ _____

Does your child use insulin to carbohydrate ratio for insulin adjustments? ☐ Yes ☐ No Ratio: _____

Does your child use an insulin adjustment for high or low blood sugar? ☐ Yes ☐ No Ratio: _____

As needed or emergency medication (such as glucagon)

Name _____ By (mouth, injection etc) _____ Dose _____ Time of day _____

_____ _____ _____ _____

Please list any side effects of this student's medication that may affect his/her learning and/or behavior:

_____

If medication is to be given at school, a medication authorization form must be completed yearly. A prescribing health professional may authorize self-administration of medication if the student is deemed capable. The medication must be in the original labeled container. When you get the prescription filled, please ask the pharmacist to put it into two containers so the student will have one for school and one for home use.

What action do you want school personnel to take if this student refuses treatment/medication. _____

_____

In an acute emergency the student will be transported by paramedics to the hospital. Transportation in a non-acute situation is the responsibility of the parent/guardian. Any charges incurred are the responsibility of the parent/guardian.

Has this student received education related to diabetes mellitus?

☐ by health care provider ☐ at support group ☐ at camp ☐ other _____

Please add anything else that you would like school personnel to know about your student's diabetes or related health condition _____

Information was provided by _____ _____ - _____

Name Relationship to Student Date

I authorize reciprocal release of information related to diabetes mellitus between the school nurse and the healthcare provider

_____ _____

Parent/Guardian Signature Date

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Equipment and Supplies

(Suggested and provided by parent/guardian, you may or may not need all items listed)

Blood Glucose Meter Kit

☐ Meter (type:_____)
☐testing strips
☐lancing device with lancets
☐cotton ball or other device to wipe blood
☐spot band-aids in case bleeding does not stop

Low Blood Glucose Supplies

☐Fast Acting Carbohydrate drink (apple juice, sugared soda, etc)
☐glucose tablets
☐glucose gel products
☐Glucagon

High Blood Glucose Supplies

☐Ketone test strips
☐Urine cup if testing urine ketones
☐water bottle

Insulin Supplies

☐Insulin pen
☐Insulin and syringes
☐Extra pump supplies

Daily Routines

Daily Snacks:

Time(s)_____

☐ Kept in Health Office
☐ Kept in classroom

☐ Done independently
☐ needs reminder
☐ needs daily compliance verification

Daily Blood test:

Time(s)_____

Will your child test before participating in ☐ gym ☐ recess ☐ after school activity

Normal range for blood glucose for your child:_____ mg/dl to _____ mg/dl

Exercise:

What are your child's favorite physical activities?_____

Will your child participate in after school sports?_____

Our guidelines indicate children should not participate in strenuous activity if blood glucose is below 80 or over 300. What guidelines do you follow for participation in physical activity? _____
_____

Parties, extra snacks, birthday treats, etc:

Do you wish to be contacted before each time? ☐ Yes ☐ No
If no, under what circumstances do you want to be contacted?_____