DIABETES QUESTIONNAIRE

Please complete and return to the School Nurse.

Student Name: ________________________________ Student ID #: __________________

Date of Birth: __________________ School Year: ________________

The following information is helpful in determining any special needs.

Person to contact:	Relationship:	Work Phone:	Home Phone:
1.______________________	______________	______________	______________
2.______________________	______________	______________	______________

Preferred communication method: ☐ Phone ☐ Written ☐ In Person ☐ Email:________________________

Health Care Provider:	Clinic:	Phone:
______________________	______________________	______________

Hospital:	Phone:
______________________	______________________

Student's age at diagnosis of diabetes ________

Does this student wear a medical alert bracelet/necklace? ☐ Yes ☐ No

Will this student need routine snacks at school? ☐ Yes ☐ No ☐ As Needed

(Snacks will need to be provided by family.)

What would you like done about birthday treats and/or party snacks? ______________________________

Should this student's blood sugar be tested at school? ☐ Yes ☐ No

If yes, what time should this student's blood sugar be monitored? ☐ A.M. ☐ P.M. ☐ As Needed

(Authorization by a health care provider is required.)

Does this student know how to test his/her own blood sugar? ☐ Yes ☐ No

Will this student need to test his/her urine for ketones at school? ☐ Yes ☐ No

Will this student need to test his/her blood for ketones at school? ☐ Yes ☐ No

What blood sugar level is considered low for this student? Below: ______________________________

How often does this student typically experience low blood sugar? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other______________________________

This student typically experiences low blood sugar during the:

☐ mid A.M. ☐ before lunch ☐ afternoon ☐ after exercise ☐ other________________________

Please check your student's usual signs/symptoms of low blood sure:

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

Does he/she recognize these signs / symptoms? ☐ Yes ☐ No

In the past year, how often has this student been treated for severe low blood sugar?______________________________

In a health care provider's office ☐ In the emergency room ☐ Overnight in the hospital ☐

In the past year, how often has this student been treated for severe diabetic ketoacidosis? ________________

In a health care provider's office ☐ In the emergency room ☐ Overnight in the hospital ☐

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What do you usually do to treat low blood sugar at home? Please be specific and state exact amount of food, beverage, glucagon, etc. (All must be provided by the family if needed at school.)

Please indicate your child's skill level for the following:

Skill	Does alone	Does with help	Done by adult	Comments
Picks / 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:

Medication Name	By (mouth, injection, etc.)	Dose	Time of Day

Insulin taken on a regular basis:

Medication Name	Type	Units	Time of Day	Delivery Method (pen, syringe, pump)

Does your child use an 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 medication:

Medication Name	By (mouth, injection, etc.)	Dose	Time of Day

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

If a 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 filling the prescription, *please ask the pharmacist for 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 does not respond to 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

Please provide any additional information that you would like school personnel to know about this student's diabetes or related health conditions.

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 health care provider.

______________________________ ______________

Parent/Guardian Signature Date