DIABETES
QUESTIONNAIRE

This form to be completed by parent and student.

Student: _____ Date of Birth: _____

School: _____ School Year: _____

Doctor: _____ Clinic Phone Number: _____

Parent/Guardian: _____ Phone Number: _____

Parent/Guardian: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

ALLERGIES/OTHER HEALTH CONDITIONS: _____

Year diagnosed with diabetes: _____ Age Diagnosed: _____

Does your child have a Continuous Glucose Monitor (CGM)?: ❒ Yes ❒ No

Does your child have an insulin pump?: ❒ Yes ❒ No Brand?: _____

Does the student wear a medical alert bracelet/necklace? ❒ Yes ❒ No

Will the student need routine snacks at school? ❒ AM ❒ PM ❒ as needed
(Snacks are to be provided, monitored and replaced by the parent as needed)

Plan for birthday snacks and/or party snacks: _____

Does the student know how to check his/her own blood sugar? ❒ Yes ❒ No

Can the student provide their own insulin? ❒ Yes ❒ No

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

How often does this student typically experience low blood sugar? ❒ Daily ❒ Weekly ❒ Monthly
❒ Other: _____

This student typically experiences low blood sugar:
❒ mid AM ❒ before lunch ❒ afternoon ❒ after exercise ❒ other: _____

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

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

Does he/she recognize these signs/symptoms? ❒ Yes ❒ No ❒ Sometimes

In the past year, has this student been treated for severe low blood sugar? ❒ Yes ❒ No

In the health care providers office? ❒ In the emergency room? ❒ Overnight in the hospital? ❒

What do you usually do to treat low blood sugar at home? Please be specific and state the exact amount of food, beverage, glucagon, etc. (ALL supplies 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
Obtains glucose sample				
Reads meter and records				
Counts carbs for meals/snack				
Interprets sliding scale				
Selects insulin injection site				
Measures insulin				
Administers insulin				
Measures Ketones				
Pump skills				

**** School communication/orders are needed from a health care provider each school year in order for your child to be in school.**

****If the student is independent in all diabetes cares, written orders from their medical provider is required each school year that indicate this. Parent/Student will also need to sign the "Permission to Self-carry and Self-Administer Diabetes Care" form yearly. Provider orders can suffice for signature on this form.**

Families are to provide all snacks for lows and diabetes supplies. Please see the diabetes checklist for further information.

It is recommended that ALL students self-carry snacks for lows. In the event of an emergency, the student may NOT be in a room that you may have supplied snacks. The school does not supply snacks across classrooms.

Is there any additional information you would like school personnel to know about this student's diabetes (or related health conditions)?:

_____

Do you give permission for the school nurse/health para to provide the information to school staff that works with your student? ❒ Yes ❒ No ❒ Other: _____

Parent/Guardian Signature: _____ Date: _____

Reviewed by: _____ Date: _____
Health Paraprofessional

_____ Date: _____
Licensed School Nurse