South Saint Paul Public Schools
OFFICE OF HEALTH SERVICES

Parent/Guardian Diabetes Questionnaire

To maximize your child's educational opportunities while maintaining optimal diabetes management requires accurate information and good communication with everyone involved – the student, parent/guardian, health professionals, school nurse and other school personnel. Please fill out and return this questionnaire to your school nurse as soon as possible.

Student Name_____ Grade _____ DOB _____

Parent/Guardian_____ Home Phone Number (_____)_____

Work Number (_____)_____ Cell/Pager Number (_____)_____

Where does your child receive his/her diabetes care (Name of clinic)_____

Name of Physician _____ Clinic Phone (____)_____

1. Age at diagnosis was _____.
2. The most recent AIC is the lab value for blood glucose control during the previous six weeks to three months. Ranges are: 6 – 8 (good), 9 – 10 (fair), 11+ (poor)._____
3. How often does your child see a physician for blood glucose evaluation? _____
4. Has your child and/or parent attended Diabetes Education classes? ☁ Yes ☁ No
5. If yes, who attended, where and when _____
6. Will your child participate in school breakfast and/or school lunch? ○Yes ○No

Equipment and Supplies
(Provided by Parent/Guardian)

Blood Glucose Meter Kit
(Includes meter, testing strips, lancing device with lancet, cotton balls, spot Band-Aids)
Type of Meter:_____

Low Blood Glucose Supplies (5 day supply – ***please label with your child's name***) - Please check ◂ appropriate supplies:
- ☁ Fast Acting Carbohydrate Drinks*:* (*Apple juice and/or orange juice, sugared soda pop-NOT diet*), at least 6 containers
- ☁ Glucose Tablets*,* 1 package or more
- ☁ Glucose Gel Products*,* 2 or more
- ☁ Other – please specify

High Blood Glucose Supplies - Please check ◂ appropriate supplies:
- ☁ Ketone Test Strips/Bottle
- ☁ Urine cup
- ☁ Water bottle

Insulin Supplies – Please check ◂ appropriate supplies:
- ☁ Insulin pen
- ☁ Insulin and syringes
- ☁ Extra pump supplies: Please specify_____

Daily Routines

Please check ◂ and complete as appropriate

Daily Snacks: Time(s)_____

- ◂ Kept in health office
- ◂ Kept in classroom
- ◂ Done independently
- ◂ Needs reminder
- ◂ Needs daily compliance verification

Daily Blood Test: Time(s)_____

- ◂ Done independently
- ◂ Needs assistance (specify)_____

Normal range for blood glucose: _____ MG/DL to _____ MG/DL

Exercise:
What are your child's favorite physical activities? _____

Will your child participate in school sports? ○Yes ○No

None if blood glucose test results are below _____ MG/DL

Parties and Special food or meals:

Do you wish to be contacted before each event? ○Yes ○No
Additional instructions for school:

Insulin at home: Brand name and type: _____

Insulin at school: ◂ Not at this time ◂ Yes ◂ Other

If Insulin at school: Brand Name and Type: _____
(*A new Insulin bottle every 30 days once vial is opened is recommended*)
Time: _____

Is student able to administer insulin independently?
◂ Yes ◂ No ◂ Requires assistance

<u>Hypoglycemia (Low Blood Sugar)</u>
Please check ◂ usual signs/symptoms of low blood sugar:

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

Does your child recognize these symptoms? ◂ Yes ◂ No

Does your child have a history of severe hypoglycemia? ◂ Yes ◂ No

Glucagon Kit at school: ◂ Yes ◂ No

Hyperglycemia (High Blood Sugar)

Please check ◂ usual signs/symptoms of high blood sugar:

- ☁ thirst
- ☁ frequent urination
- ☁ fatigue
- ☁ dry skin
- ☁ other _____
- ☁ blurred vision
- ☁ drowsiness
- ☁ nausea/vomiting
- ☁ behavior changes

Does your child recognize these symptoms? ☁ Yes ☁ No

Hyperglycemia treatment at school: _____

What concerns or questions do you have about your child's diabetes management while at school?

_____
_____
_____
_____

How can the school Health Office staff assist you with your child's diabetes management?

_____
_____
_____
_____

Information pertinent to student safety will be shared with appropriate school personnel.

Parent/Guardian Signature_____ Date _____

Feel free to call the school nurse with any concerns or questions.

Nurse Name _____ Phone (____)_____

Thank you for filling out this questionnaire.