CARROLL COUNTY PUBLIC SCHOOLS
DIABETIC-PARENT HEALTH QUESTIONNAIRE

Date: ____________                                                                 School Year: _______________________

To the Parent(s)/Guardian(s) of: _________________________________________________________
DOB: ________ Grade: ________

Please complete and return to the School Nurse.
The following information is helpful in determining any special needs.
Child's age at diagnosis of Diabetes: __________________

Does your child wear a medical alert bracelet/necklace? □ Yes □ No

Will your child need routine snacks at school? □ A.M. □ P.M. □ as needed
(Snacks will need to be provided by the family)

What time should your child’s blood sugar be monitored? □ A.M. □ P.M. □ as needed
(Authorization by a health care provider is required.)

Does your child know how to check his/her own blood sugar? □ Yes □ No

Will your child need to test his/her urine for ketones at school? □ Yes □ No

Will your child need to test his/her blood for ketones at school? □ Yes □ No

What blood sugar level is considered low for your child? below _____________

How often does your child typically experience low blood sugar?
□ Daily □ Weekly □ Monthly □ Other _______________

When does he/she typically experience low blood sugar?
□ mid A.M. □ before lunch □ afternoon □ after exercise □ other ________________

Please check your child’s usual signs/symptoms of low blood sugar.
□ 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 symptoms? □ Yes □ No

In the past year, how often has your child 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 your child been treated for severe high blood sugar or Diabetic ketoacidosis? _______
□ In a health care provider’s office □ In the emergency room □ Overnight in the hospital

What is your child’s latest A1C? ____________________________

Date / Result: ______________
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 supplies must be provided by the family if needed at school.)

________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

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

<table>
<thead>
<tr>
<th>Skill</th>
<th>Does Alone</th>
<th>Does with help</th>
<th>Done by adult</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain glucose sample</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reads meter and records</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counts carbs for meals/snack</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interprets sliding scale</td>
<td></td>
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<tr>
<td>Selects insulin injection site</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measures insulin</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Administers insulin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measures ketones</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pump skills</td>
<td></td>
<td></td>
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</tbody>
</table>

Insulin taken on a regular basis: Name: _______________________ Type: ______________
How many units and time of day taken:__________________________________________
Delivery Method (please circle) Pen Syringe Pump
Does your child use an insulin to carbohydrate ratio?  □ Yes  □ No  Ratio: ______________
Correction factor (insulin sensitivity):________________________________________

Does your child adjust the insulin dose for high or low blood sugar?  □ Yes  □ No
Other medication(s) taken on regular basis:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Time of Day</th>
<th>Route (mouth, injection, etc)</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
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</table>

As needed medication(s) that your child takes:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Time of Day</th>
<th>Route (mouth, injection, etc)</th>
<th>Dose</th>
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Please list any known medication side effects that may affect your child’s learning and/or behavior:

________________________________________________________________________________________________
________________________________________________________________________________________________
If insulin is to be given at school, a medication authorization form must be completed yearly. A prescribing health professional may authorize self-administration of insulin if the student is deemed capable. The medication must be in the original labeled container.

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 your child received Diabetes education? ☐ by health care provider ☐ at support group ☐ at camp ☐ other

Please add anything else that you would like school personnel to know about your child’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: ______________

Reviewed by School Nurse: ________________________________ Date: ______________

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