Forest Lake Area Schools
Health Services - Nursing

Diabetes Questionnaire

School Year: ____________

Student Name: ____________________________________ Birthdate: ___________________________

School Attending: _________________________________ Grade: ______________________________

Parent/Legal Guardian:______________________________ Relationship to Student: _______________

Home Phone: __________________ Work: ______________________ Cell: ______________________

Parent/Legal Guardian:______________________________ Relationship to Student: _______________

Home Phone: __________________ Work: ______________________ Cell: ______________________

Primary Physician: _______________________ Clinic: _________________ Phone: ________________

Endocrinologist: _________________________ Clinic: _________________ Phone: ________________

1. Has the student been diagnosed with diabetes by a healthcare provider? ☐ Yes ☐ No
2. Indicate what type of diabetes the student has been diagnosed with (circle which one applies):

   Type 1 Type 2 Other
3. When was the student diagnosed with diabetes? ____________ How old was your child? __________
4. Does the student wear a medical alert bracelet/necklace? ☐ Yes ☐ No
5. Will the student need routine snacks at school? ☐ Yes ☐ No ☐ A.M. ☐ P.M. ☐ as needed
   a. What would you like done about birthday treats and/or party snacks? ____________________
6. Will the student's blood sugar need to be checked at school? ☐ Yes ☐ No
   a. What time(s) should the student's blood sugar be checked? ____________________________
   b. Does the student know how to check their own blood sugar? ☐ Yes ☐ No
7. Will the student need to test their urine for ketones at school? ☐ Yes ☐ No
8. Will the student need to test their blood for ketones at school? ☐ Yes ☐ No
9. What blood sugar level is considered low for the student? below ______________________________
   a. How often does the student typically experience low blood sugars?

      ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ____
   b. When does the student typically experience low blood sugars?

      ☐ mid A.M. ☐ before lunch ☐ afternoon ☐ after exercise ☐ Other _____________

Please Complete All Pages

10. Please check the student's usual signs/symptoms of low blood sugar.

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

11. Does the student recognize these signs/symptoms? ☐ Yes ☐ No
12. In the past year, how often has this student been treated for low blood sugar? ___________________
    ☐ In a health care provider's office ☐ In the emergency room ☐ Overnight in the hospital
13. What do you usually do to treat low blood sugar at home (please be specific, stating exact amount of food, beverage, glucagon, etc) ____
14. In the past year, how often has this student 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
15. Does the student use an insulin to carbohydrate ratio for insulin adjustments? ☐ Yes ☐ No
16. Does the student use an insulin adjustment for high or low blood sugar? ☐ Yes ☐ No

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

Skill	Done alone	Done with help	Done by adult	Comments
Obtain 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				

Please Complete All Pages

Insulin taken on a regular basis:

Name	Type	Units	Time of day	Delivery Method (Pen, syringe, pump)

Other medication taken on regular basis:

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

As needed medication:

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

Please list any known medication side effects that may affect the student's learning and/or behavior:
____
____
____

What action do you want school personnel to take if the 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/legal guardian. Any charges incurred are the responsibility of the parent/ legal guardian.

Has the student received diabetes education? ☐ Yes ☐ No
☐ by health care provider ☐ at support group ☐ at camp ☐ Other
____

Please add anything else that you would like school personnel to know about the student's diabetes (or related health conditions) ____
____

Please Sign Back Page

Parent/Legal Guardian Signature: ________________________________ Date: ________________

Please note:

- Diabetic supplies and routine snacks for the student **MUST** be provided by the parent(s)/legal guardian(s)
- If your child has diabetes, we request that you make accommodations with the health office regarding the student's medications, supplies, snacks & signed authorizations/forms
- Please fill out and submit an *Authorization for Medication at School Form*, *Diabetic Agreement*, and provider/prescriber's diabetic orders/care plan to the appropriate health office
- If the student is in 7-12th grade and the parent/legal guardian and provider/prescriber feel the student can self-carry, self-administer and self-manage their diabetes, please also fill out and submit a *Self-Carry/Self-Administer Authorization Form* and *Diabetes Self Management Authorization Form* to the appropriate health office. **NOTE:** This request is considered on a case-by-case basis by the LSN/RN.