



**ALEXANDRIA
Public Schools**

Our Mission

To achieve educational excellence and to inspire a life-long passion for learning.

Our Vision

To be an extraordinary school district that tailors learning for each child, by working together!

DIABETES QUESTIONNAIRE

{This form is to be completed by the parent and student} **New Forms are required each school year**

Student's name:	Date of birth:
School:	School Year:
Name of Physician:	Clinic Name and phone number:

Parent/Guardian:	Phone Number:
Parent/Guardian:	Phone Number:
Emergency Contact:	Phone Number:

Year diagnosed with diabetes: _____

Does your child have a Continuous Glucose Monitor (CGM) Yes No Brand: _____

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

Allergies/Other health conditions: _____

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: _____

Alexandria Public Schools - ISD #206

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:

- | | | |
|--|---|---|
| <input type="checkbox"/> hunger or 'butterfly feeling' | <input type="checkbox"/> irritable | <input type="checkbox"/> difficulty with speech |
| <input type="checkbox"/> shaky/trembling | <input type="checkbox"/> weak/drowsy | <input type="checkbox"/> uncoordinated |
| <input type="checkbox"/> dizzy | <input type="checkbox"/> inappropriate crying or laughing | <input type="checkbox"/> confused/disoriented |
| <input type="checkbox"/> sweaty | <input type="checkbox"/> severe headache | <input type="checkbox"/> loss of consciousness |
| <input type="checkbox"/> rapid heartbeat | <input type="checkbox"/> impaired vision | <input type="checkbox"/> seizure activity |
| <input type="checkbox"/> pale | <input type="checkbox"/> anxious | <input type="checkbox"/> 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				



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**** 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 care, written orders from their medical provider is required each school year that indicate this. Parent/Guardian/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

Health Paraprofessional

Date

Registered Nurse

Date