FOR SCHOOL NURSE
SCHOOL INTAKE INTERVIEW – DIABETES

Student Name:____Date of Birth:______________
School:______________________________ Grade:__________ Homeroom Teacher:____________
Parent/Guardian:____
Phone (Home):_____________________Phone (Work):______________Other:_______________
Physician Name:____________________Office Phone:____________________ Fax: ____________
Diabetes Nurse Educator's Name:________________________________ Office Phone:____________
Age of Diagnosis:________Diabetes: Type 1:_____ Type 2:_____ Last A1c:_____ Next Appt:__________
History of Hospitalization:____
Mode of Transportation to and from School? Parent:__________ Bus:___Duration of ride:__________
Bus Driver notified of diabetes? Yes:___________ No:______________
Does child participate in after school activities? Yes:__________ No:____________
Explain: ____
Does child attend Before and After Care? Yes:_______ Before:________ After:_________ No:________
Field Trip Recommendations: ____
Field Trip Adult designated/notified of diabetes? Yes:__________ No: ____________

Blood Sugar Monitoring:

Test will be performed in____ (location)
Needs assistance with testing? Yes:__________ No:____________
Required Test Times: ____
Call Parent if blood sugar is below:_____________ Above: ___________________
Continuous Glucose Monitor Model:______________Alarm Parameters: Low:______High:______
Phone or Receiver Code for CGM: None:_______Code:________________________________
Parent notification of Blood Glucose: Daily_____Weekly:_____Via Email:______________________
Text:________________Phone Call:___________________Paper Copy:________________
Comments:____

Meds: Insulin:

Can student give own injection? Yes:_______No:_______Comments:______________________
Time(s) insulin to be administered at school:_______________________________________
Form of Administration: Injection:_____ Pen:________
Discuss Insulin Expiration at 28 days: ____
Pump: Model:__________________________CGM Model:______________ Yes:___ No:___
Glucagon Ever Used: Yes:_____ No:_____If yes, date(s):________________________________
Oral Medications: Type:______________________Dose:___________Times:_____________
Comments:____

Diet:

Student Lunch Time:_____________Dose: Before:_______After:_______ Split:_____________
Does Student have special dietary needs: Yes:__________________________________No:____
Is Assistance Required for meals or snacks: Yes:_____ No:_____ Explain:___________________
Snack will be eaten in:____(location)
Snacks will be stored in:____(location)
Recommended Snacks:____
Parent wishes to be notified in advance of class parties? Yes:_______ No:______
Child may partake in class treats? Yes:______ No:_____ Explain:____________________________
Comments:____

SCHOOL NURSE SCHOOL
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Physical Education:
Scheduled at:____________Blood Glucose or CGM check: Yes:_____No:______Before:_____After:______
Is snack necessary before PE? Yes:_____No:_____ BG/CGM parameters if any:______________________
Does student participate in after school sports? Yes:_____No:____What sport?___________________
Comments: ____

Communication:
Whom to notify first?____
Preferred Communication: Cell:_______Text:________Email:___________________________
Comments: ____

Emergency: Lockdown, Lockout, Shelter in Place, Evacuate protocols
Snack location(s): Parents may want to supply extra classrooms with water, sugar source and/or complex carbohydrate snacks in ziplock bags for emergencies.
Classroom_____Art Class_____PE_____Music_____Library_____SPED Classroom_____ Computer Lab____
Other ____

Diabetes Concerns:
What does the student know regarding their diabetes?_____________________________________
____
What concerns does the student have regarding their diagnosis?______________________________
____
What concerns do the parents have regarding their child's diagnosis?__________________________
____
Describe any experiences – good or bad – at your student's last school.________________________
____
How can we support you with training needs for student, parent or staff and/or school supports.__________
____
Comments:____

Reminders:

***Give Standards of Care for Diabetes Management to the Family**

***Give Continuous Glucose Monitoring Guidelines if applicable**

***Obtain Student's Schedule to collaborate testing times**

***Discuss 504**