DIABETES HISTORY **STUDENT NAME**_____ **DATE** _____

The following form will assist the school nurse and staff in determining any special needs for your child and the development of an individualized healthcare plan (IHP). This form is to be completed at initial IHP development and every 2 years thereafter unless there are changes.

1. When was your child diagnosed with diabetes:_____ ☐ Type 1 ☐ Type 2

Managing Licensed Healthcare Provider: _____ Phone: _____

2. History of Current Status:

a) Age of child when diabetes was first diagnosed: _____

a. Have there been emergency room visit(s)? ☐ No ☐ Yes
   If yes, when and where: _____

b. Has your child been admitted to the hospital? ☐ No ☐ Yes
   If yes, when and where: _____

c. Has your child ever needed emergency medication? ☐ No ☐ Yes
   If yes, when and where: _____
   Emergency medication used: _____

3. Management:

How does your child manage diabetes? ☐ **Insulin Injections** ☐ **Insulin Pump** ☐ **Continuous Glucometer**

Insulin type(s) used:

_____

Insulin pump used:

_____

Glucometer used:

_____

Emergency medication currently prescribed:

_____

How does your child communicate symptoms? _____

How quickly does your child communicate symptoms? _____

4. Self-care blood glucose checking skills:

- ☐ Independently checks own blood glucose and understands what the reading indicates.
- ☐ May check blood glucose with supervision.
- ☐ Requires a school nurse or trained diabetes personnel to check blood glucose.
- ☐ Uses a smartphone or other monitoring technology to track blood glucose value.

5. Self-care insulin administration skills:

- ☐ Independently calculates and gives own injections.
- ☐ May calculate/give own injections with supervision.
- ☐ Requires school nurse or trained diabetes personnel to calculate dose and child can give own injection with supervision.
- ☐ Requires school nurse or trained diabetes personnel to calculate dose and give the injection.

****Continued on reverse**

6. Self-care nutrition skills:

- ☐ Independently counts carbohydrates.
- ☐ May count carbohydrates with supervision.
- ☐ Requires school nurse/trained diabetes personnel to count carbohydrates.

7. Self-Care:

a. Is your child able to recognize and monitor their diabetic symptoms? ☐ No ☐ Yes

b. Does your child:

Communicate hyperglycemic symptoms	☐ No	☐ Yes
Communicate hypoglycemic symptoms	☐ No	☐ Yes
Tell an adult immediately when symptoms occur	☐ No	☐ Yes
Wear a medical alert bracelet, necklace, watchband	☐ No	☐ Yes
Tell peers and adults about their diabetes	☐ No	☐ Yes
Know how to use their emergency medication	☐ No	☐ Yes
Ever administered their own emergency medication	☐ No	☐ Yes

8. Family/Home

a. Does your child care for their diabetic needs at home? ☐ No ☐Yes

b. Do you feel that your child needs assistance in coping with diabetes? ☐ No ☐Yes

9. General Health:

a. How is your child's general health other than having diabetes?

_____

b. Does your child have any other health conditions?

_____

c. Please add anything else you would like the school to know about your child's health:

_____

_____

Parent/Guardian Signature: _____Date: _____

Reviewed by:_____Date: _____