PITTSFORD CENTRAL SCHOOL DISTRICT
Parent Interview Questionnaire for Individualized Health Plan
DIABETES MELLITUS

Child's Name _____ Birthdate _____ Age _____ Grade _____
Teacher _____ Information provided by _____ Date _____

Please answer all questions. Use the back of this form for explanation or any additional information you feel important for us to know.

Who does your child see for regular health visits? _____ Phone _____
Who does your child see for diabetes management? _____ Phone _____
When was your child diagnosed with diabetes? _____ at age _____
Has your child been diagnosed with any other medical conditions?
☐ No ☐ Yes (explain) _____
Who is (are) your child's primary caregiver(s)? _____
Is (are) the primary caregiver(s) knowledgeable about the diabetic diet, symptoms of high/low glucose, effect of exercise/infection on glucose level and treatment of diabetes? ☐ No ☐ Yes
Has your child taken diabetes classes or camps? ☐ No ☐ Yes When? _____
Has your child been hospitalized for diabetes? ☐ No ☐ Yes
If yes, when and for what? _____
Is your child knowledgeable about his/her diet? ☐ No ☐ Yes
Does your child follow his/her prescribed diet? ☐ No ☐ Yes
How often does your child check his/her glucose each day? _____
What medications does your child take to manage his/her diabetes?

Name of Medication	**Amount**	**When taken**

Has your child been instructed on when and how to take these medications independently? ☐ No ☐ Yes
Is your child's diabetes under good control? ☐ No ☐ Yes Glucoses range from _____ to _____
Is your child aware of the symptoms/signs of low blood glucose/insulin reaction? ☐ No ☐ Yes
How would your child describe these symptoms? _____
Does your child know what to do when early insulin reaction symptoms begin? ☐ No ☐ Yes
Is your child aware of the symptoms/signs of high blood glucose/diabetic ketoacidosis? ☐ No ☐ Yes
Is your child aware of the effect of exercise on blood glucose? ☐ No ☐ Yes
Has diabetes caused your child to miss school? ☐ No ☐ Yes
What are your child's feelings about having diabetes? _____
Is your child comfortable alerting others when experiencing problems with his/her diabetes? ☐ No ☐ Yes
Is your child participating in sports or school sponsored extracurricular activities? ☐ No ☐ Yes
Does your child carry a glucose monitoring machine, snacks, glucose tablets, glucagon when participating in sports or extracurricular activities? ☐ No ☐ Yes (circle all that apply)
Are there any barriers to management of your child's diabetes (knowledge deficit, equipment, emotional issues/opposition to treatment, family issues, financial issues, etc.)? ☐ No ☐ Yes (please describe)
Does your child wear a "**medic alert**" necklace/ bracelet? ☐ No ☐ Yes
Has your physician indicated **in writing** that your child needs any special accommodations in school?
☐ No ☐ Yes (explain) _____

Comments: _____

Pittsford Central Schools

Parent Consent/Physician Authorization/Emergency Care Plan
For Management of Diabetes at School and School Sponsored Events

Pupil:	**School:**	**Grade:**	**DOB:**

Physician's Written Authorization: Please initial and check all boxes that apply

1. Blood Glucose Testing
☐Before am snack ☐Before lunch ☐2 hours after lunch
☐2 hours after a correction dose ☐For suspected hypoglycemia
☐At student's discretion excluding suspected hypoglycemia
☐Only at student's discretion ☐No blood glucose testing at school
Target range for blood glucose at school_____

2. Hypoglycemia - blood glucose less than 70: see reverse side
☐Self treatment of mild lows ☐Assistance for all lows
☐Provide extra protein & carb snack after treating lows
or feed snack/meal early (if scheduled within the hour)
☐OK to use glucose gel inside cheek; even if unconscious
☐Glucagon injection IM (for severe hypoglycemia): __0.5 mg
When nurse is available __1 mg

3. Hyperglycemia: see reverse side
☐If blood glucose >_____ initiate insulin administration order
☐If blood glucose >_____or exhibit symptoms of ketosis, check ketones
☐Check urine ketones ☐Check blood ketones

4. Meal Plan
Snacks/meals: ☐Mandatory ☐At student's discretion
☐AM snack time: _____ ☐PM snack time: _____
☐Lunch time:_____ Other:_____
☐Extra food allowed: ☐Parent's discretion ☐Student's discretion

5. Exercise (Check and/or complete all that apply):
Liquid and solid carb sources must be available before, during and after all exercise.
☐Check glucose before exercise
☐No exercise if most recent blood glucose is <70 until treated as above
☐Eat ___gms CHO for vigorous exercise:
☐Before, ☐Every 30 minutes during, ☐After
☐No exercise when blood glucose is > ___or ketones are present

6. Physician/NP Verification: Student can self-perform the following procedures (parent and school nurse must verify competency as well
☐Blood glucose testing ☐Measuring insulin ☐Injecting insulin
☐Determining insulin dose ☐Independently operate insulin pump
☐Other _____

7. Insulin Orders
Brand name and type_____

Administration times (fill in times for only those that apply):
☐Breakfast ☐AM snack ☐Lunch ☐PM snack
☐Other: _____

Insulin administration via:
☐Syringe and vial ☐Insulin pump ☐Insulin pen ☐Inhaled insulin
Other:_____

Insulin dose determined by (Check all that apply):
Food/bolus doses:
☐Standard lunchtime dose:_____
☐Insulin to carbohydrate ratio:
_____# unit(s) insulin per _____ gms Carbohydrate
☐Correction Calculation (complete only those that apply)

- Give _____unit(s) for every _____mg/dl above _____mg/dl
- Decrease correction by ___% unit(s) if PE or increased activity is anticipated after correction dose, or last dose was given less than 2 hours before.

☐**Written sliding scale as follows**:
Blood Glucose from _____ to _____ = _____Units
Blood Glucose from _____ to _____ = _____Units
Blood Glucose from _____ to _____ = _____Units
Blood Glucose from _____ to _____ = _____Units

☐**Add carb calculation insulin dose and correction calculation for total insulin dose/bolus**
☐**Permission for parent to adjust insulin dosing**

8. Bus Transportation:
☐Blood glucose test not required prior to boarding bus
☐Test blood glucose 10 to 20 minutes before boarding bus
- Provide 15 gm glucose source if blood glucose is<_____mg/dl
- Provide care as follows:_____

Other: _____
_____

Other Needs: Specify on physician stationary or prescription pad and attach.

Parent Consent for Management of Diabetes at School

I(We), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the following specialized physical health care service for Management of Diabetes in school be administered to our (my) child in accordance with state laws and regulations.
I will: 1. Provide the necessary supplies and equipment
2. Notify the school nurse if there is a change in pupil health status or attending physician
3. Notify the school nurse immediately and provide new consent for any changes in doctor's orders
I authorize the school nurse to communicate with the physician when necessary.

Parent/Guardian Signature _____Print Name: _____Date _____

Home: _____Work: _____Cell: _____Emergency Contact: _____Phone: _____

Physician Authorization for Management of Diabetes at School

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. If changes are indicated, I will provide new written authorization (may be faxed).
Physician Signature_____ **Phone**: _____ **Date** _____

Reviewed by School Nurse (Signature)_____ Date _____ Valid for _____school year

CAUSES
Too much insulin
Missed food
Delayed food
Too much exercise
Unscheduled exercise

ONSET

Sudden

Symptoms

MILD

Hunger	Dizziness
Irritable	Pallor
Shakiness	Sweating
Weak	Drowsy
Sweaty	Crying
Anxious	Headache

Unable to concentrate
Numbness of lip and tongue
Other: _____

MODERATE
Sleepiness
Erratic behavior
Poor coordination
Confusion
Slurred speech

SEVERE
Unable to swallow
Combative
Unconscious
Seizure

ACTION NEEDED
Notify School Nurse
If possible, check glucose per plan
But, always when in doubt
TREAT

MILD
- Provide sugar source
  2-3 glucose tablets or
  4 to 8 oz. juice or
  4 to 8 oz. regular soda or
  Glucose gel product
- Wait 10 minutes
- Repeat sugar source if symptoms persist or blood glucose less than 70.
- Provide a snack of carbohydrate and protein, i.e. crackers and cheese.
- Communicate with parents.

MODERATE
- Provide sugar source
  3 glucose tablets or
  15 gm. Glucose gel
- Wait 10 minutes. Repeat glucose if symptoms persist or blood glucose less than 70.
- Follow with a snack of carbohydrate and protein, i.e. crackers and cheese.
- Notify parents.

SEVERE
- Call 911
- Provide glucose gel 15 gm. inside cheek even if unconscious
- Give Glucagon, if ordered.
- Position on side
- Contact parents and school nurse

SYMPTOMS OF HIGH BLOOD GLUCOSE (Hyperglycemia)

CAUSES
Too much food or drink
Not enough insulin
Illness
Stress

Onset

Gradual

SYMPTOMS
Frequent urination
Extreme thirst
Dry skin
Blurred vision
Hunger
Nausea
Fatigue
Poor exercise performance