CARROLL COUNTY PUBLIC SCHOOLS

Parent Health Questionnaire – Diabetes

Date: _____ School Year: _____

To the Parent(s)/Guardian(s) of: _____

DOB: _____ Grade: _____

Please complete and return to the School Nurse.

The following information is helpful in determining any special needs.

Child's age at diagnosis of Diabetes: _____

Does your child wear a medical alert bracelet/necklace? ☐ Yes ☐ No

Will your child need routine snacks at school? ☐ A.M. ☐ P.M. ☐ as needed
(Snacks will need to be provided by the family)

What time should your child's blood sugar be monitored? ☐ A.M. ☐ P.M. ☐ as needed
(Authorization by a health care provider is required.)

Does your child know how to check his/her own blood sugar? ☐ Yes ☐ No

Will your child need to test his/her urine for ketones at school? ☐ Yes ☐ No

Will your child need to test his/her blood for ketones at school? ☐ Yes ☐ No

What blood sugar level is considered low for your child? below _____

How often does your child typically experience low blood sugar?

☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

When does he/she typically experience low blood sugar?

☐ mid A.M. ☐ before lunch ☐ afternoon ☐ after exercise ☐ other _____

Please check your child's usual signs/symptoms of low blood sugar.

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

Does he/she recognize these symptoms? ☐ Yes ☐ No

In the past year, how often has your child been treated for severe low blood sugar? _____

☐ In a health care provider's office ☐ In the emergency room ☐ Overnight in the hospital

In the past year, how often has your child 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

What is your child's latest A1C? _____

Date / Result: _____

What do you usually do to treat low blood sugar at home? Please be specific and state 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**
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				

Insulin taken on a regular basis: Name: _____ Type: _____

How many units and time of day taken: _____

Delivery Method (please circle) Pen Syringe Pump

Does your child use an insulin to carbohydrate ratio? ☐ Yes ☐ No Ratio: _____

Correction factor (insulin sensitivity): _____

Does your child adjust the insulin dose for high or low blood sugar? ☐Yes ☐ No

Other medication(s) taken on regular basis:

Medication Name	Time of Day	Route (mouth, injection, etc)	Dose

As needed medication(s) that your child takes:

Medication Name	Time of Day	Route (mouth, injection, etc)	Dose

Please list any known medication side effects that may affect your child's learning and/or behavior:

_____

_____

If insulin is to be given at school, a medication authorization form must be completed yearly. A prescribing health professional may authorize self-administration of insulin if the student is deemed capable. The medication must be in the original labeled container.

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/guardian. Any charges incurred are the responsibility of the parent/guardian.

Has your child received Diabetes education? ☐ by health care provider ☐ at support group ☐ at camp ☐ other

Please add anything else that you would like school personnel to know about your child's Diabetes (or related health conditions).

_____

_____

_____

_____

_____

Information was provided by: _____ _____

Name:_____ Relationship to Student: _____ Date: _____

I authorize reciprocal release of information related to diabetes mellitus between the school nurse and the health care provider.

Parent/Guardian Signature: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____

Rev. 7/2024