



DIABETES QUESTIONNAIRE

Student: \_\_\_\_\_

School: \_\_\_\_\_ School Year \_\_\_\_\_

Grade/Teacher \_\_\_\_\_ DOB \_\_\_\_\_

Please complete and return to the Nurse at School.

Person to contact:	Relationship:	Work Phone:	Home Phone:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
Preferred Communication method: Phone _____ Written _____ In Person _____ Email: _____			
Health care Provider _____		Phone: _____	
Address _____			

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 would you like done about birthday treats and/or party snacks? \_\_\_\_\_

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

- |  |   |   |
|--|---|---|
| <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"/> difficulty with coordination |
| <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

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

Adapted with permission from National Association of School Nurses H.A.N.D.S., SM 2010

## DIABETES QUESTIONNAIRE

HS P-3

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 / snacks				
Interprets sliding scale				
Selects insulin injection site				
Measures insulin				
Administers insulin				
Measures ketones				
Pump skills				

Insulin taken on a regular basis:

Name	Type	Units	Time of day	Delivery Method (Pen, syringe, pump)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Does your child use an insulin to carbohydrate ratio for insulin adjustments? \_\_\_Yes \_\_\_No Ratio: \_\_\_\_\_

Does your child use an insulin adjustment for high or low blood sugar? \_\_\_Yes \_\_\_No Dose: \_\_\_\_\_

Other Medication taken on a regular basis:

Name	By (mouth, injection, etc.)	Dose	Time of Day
_____	_____	_____	_____
_____	_____	_____	_____

As needed medication:

Name	By (mouth, injection, etc.)	Dose	Time of Day
_____	_____	_____	_____
_____	_____	_____	_____

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

\_\_\_\_\_

If a medication is to be given at school, a medication authorization form must be completed yearly. A prescribing health professional may authorize self-administration of medication if the student is deemed capable. The medication must be in the original labeled container. When you get the prescription filled, please ask the pharmacist to put it into two containers so the student will have one for school and one for home use.

What action do you want school personnel to take if your child does not respond to treatment/medication?

\_\_\_\_\_

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 nurse at school and my child's health care provider.

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

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