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About Medical Questionnaires

What is a Questionnaire?

A questionnaire is an extensive collection of questions intended for parents or guardians to complete concerning the student's medical history, current health condition, self-care habits, psychosocial and cultural needs, along with academic achievements. The information gathered from these questions aids the school nurse in developing a custom Individualized Health Care Plan (IHCP). This foundational information equips the school nurse with the necessary details to create a plan that ensures the student's safety and supports their academic success. The last page of the questionnaire includes consents which must be completed annually.

What is an Individualized Health Care Plan (IHCP)?

An Individualized Health Care Plan (IHCP) is what a school nurse develops for students with chronic or substantial health conditions that necessitates continuous direct or indirect support from the school nurse. This document is typically distributed among APS health personnel to ensure consistent nursing care. It includes a brief past medical history, student's healthcare team members, emergency contacts, any allergies, list of medications, nursing diagnoses, nursing interventions and student health goals.

What if I've already completed a Questionnaire?

For students who are returning to school and may already have a questionnaire on record, we kindly request that you, as the parent or guardian, update or edit any changes that may have taken place over the past year. A printed copy of last year's questionnaire will be provided to you for review. The parent or guardian **must also complete the "CONSENT" portion of the questionnaire annually.**

My child has a NEW diagnosis or is NEW to the school

For new students in the district or a student that has a new diagnosis, we ask you to complete a questionnaire to the best of your ability so that a comprehensive Individualized Health Care Plan (IHCP) can be made.

I value your help in ensuring a safe and healthy school atmosphere for your child, as this will allow them to be at their healthiest and achieve optimal academic performance.

Sincerely,

X

Nicole Quadros, RN, BSN

Sgt. Jordan Shay Memorial Lower Elementary School Nurse

Please **complete all questions**. This information is essential in determining your child's needs and assisting us to better provide a positive, supportive, and safe learning environment.

This questionnaire was adapted by the American Diabetes Association at www.diabetes.org.

Student's Name: _____ DOB: _____ Grade: _____

Student's Address: _____ Student's Cell Phone #: _____

Date of DM diagnosis: _____ (circle one) Diabetes Type I Diabetes Type II

Student's Endocrinologist / Prescribing Physician: _____ Phone: _____ Fax: _____

Affiliated Hospital: _____ Address: _____

Student's Primary Care Doctor: _____ Phone: _____ Fax: _____

Affiliated Hospital: _____ Address: _____

Significant Medical History or Conditions: _____

Any known allergies to medication or food? ☐ No ☐ Yes. List **all** allergies: _____

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

When will your child need blood glucose level checked? (i.e. morning, meal time, before gym, dismissal, etc.)

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

What blood glucose level is considered low for your child? _____

How often does your child typically experience a blood glucose level?

☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _____

My child typically experiences low blood sugar:

☐ mid A.M. ☐ before lunch ☐ afternoon ☐ after exercise ☐ Other: _____

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

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

Does the student recognize these signs/symptoms? ☐ Yes ☐ No Feel free to comment below:

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

If 'yes' to the above, who was the low blood sugar treated by? (check all that apply)

- ☐ parents/guardians ☐ health care provider's office ☐ emergency room ☐ hospitalization

Has your child ever been administered glucagon? ☐ Yes ☐ No If yes, when? _____

What would you usually do to treat low blood glucose levels at home? (Please be specific and state exact amount of food, beverage, glucose tabs/gel, glucagon, etc): _____

What blood glucose level is considered high for your child? _____

What are your child's usual signs/symptoms of a high blood glucose level? _____

Does the student recognize these signs/symptoms? ☐ Yes ☐ No

In the past year, how often has your child been treated for severe high blood glucose or diabetic ketoacidosis?

Who was it treated by? (check all that apply)

- ☐ parents/guardians ☐ health care provider's office ☐ emergency room ☐ hospitalization

Meals and Snacks Eaten at School

Meal / Snack	Time	Food Content / Amount
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Other	_____	_____
Other	_____	_____

Snack before exercise? ☐ Yes ☐ No Snack after exercise? ☐ Yes ☐ No

Other times to give snacks and content/amount: _____

Exercise and Sports

A fast acting carbohydrate such as _____ should be available at the site of exercise or sports.

Restrictions on activity, if any: _____

Student should not exercise if blood glucose is below _____ mg/dL or above _____ mg/dL or if student has moderate to large ketones present.

For Student with Insulin Pumps

Type of pump: _____

Type of insulin in pump: _____ Type of infusion set: _____

Supplies to be Kept at School (equipment and snacks will be provided by parent)

- ☐ Blood glucose meter, test strips, batteries
- ☐ Lancet device, lancets, etc.
- ☐ Ketone strips / meter
- ☐ Insulin pump and supplies including insulin
- ☐ Insulin pen, pen needles, insulin cartridge
- ☐ Fast-acting source of glucose
- ☐ Carbohydrate containing and long acting snacks to be kept with student, health office and all necessary classrooms
- ☐ Glucagon emergency kit

As parent/guardian, I understand that is my responsibility to provide proper **equipment, supplies and snacks** for my child during school hours and during school events.

Date

Parent/Guardian Print

Initials

Student Skills Assessment

Student Without Pump Abilities/Skills:	Needs Assistance	
Counts carbs for meals/snacks	YES	NO
Selects insulin injection site	YES	NO
Measures insulin	YES	NO
Administers insulin	YES	NO
Measures ketones	YES	NO

Student Pump Abilities / Skills:	Needs Assistance	
Bolus correct amount for carbohydrates consumed	YES	NO
Calculate and administer corrective bolus	YES	NO
Calculate and set basal profiles	YES	NO
Calculate and set temporary basal rate	YES	NO
Disconnect pump	YES	NO
Reconnect pump at infusion set	YES	NO
Prepare reservoir and tubing	YES	NO
Insert infusion set	YES	NO
Troubleshoot alarms and malfunctions	YES	NO
Measure ketones	YES	NO

If this is a newer diagnosis (within the past year), has your child received diabetes education?

(check all that apply)

☐ health care provider ☐ support group meetings ☐ camp ☐ other: _____

Could you please describe your child's emotional response to their condition and their response: _____

Do you, the parent/guardian, have any interest with training/orientation being provided in your child's classroom?

Please add anything else you would like school personnel to know about your child's diabetes and/or other health conditions: _____

Notify parent(s)/guardian(s) or emergency contacts in the following situations: _____

APS Student _____ Student Name _____ DOB: _____ DOB _____

CONSENT

Initials I consent to the release of information contained in this Diabetes Questionnaire to staff members and other adults who have custodial care of my child or have a legitimate educational interest in my child to maintain my child's health and safety.

Initials I consent to the release of information contained in the Diabetes Medical Management Plan (DMMP) to staff members and other adults who have custodial care of my child or have a legitimate educational interest in my child to maintain my child's health and safety.

Initials In addition to this plan, I will provide the school nurse with a copy of the school orders from my child's physician.

Initials The school nurse has permission to contact my child's physician regarding this diagnosis.

Initials My child has permission to self-administer the above medications at school and/or school events, if the school nurse deems it appropriate.

By signing below, I agree that the information on this Seizure Care Plan Questionnaire in regards to my child has been answered to the best of my ability. Should there be any changes to my child's health status, I acknowledge that it is my responsibility to notify the nurse as soon as possible.

Parent/Guardian Print _____
Initials X
Parent/Guardian Signature _____ Today's Date _____

School Nurse Print _____
Initials X
School Nurse Signature _____ Today's Date _____

APS nurses would like to make you aware of the following:

Sharing PII *without* Parental Consent

While obtaining consent is usually the best way to ensure compliance with state and federal law, it may sometimes prove impracticable. In these situations, certain narrow FERPA exemptions allow schools to disclose student information without consent. For example, students' educational records (including health information) may be shared with any of the following persons or in any of the following situations:

1. with school officials with a "legitimate educational interest,"
2. with other schools to which the student is transferring,
3. to comply with a judicial order or valid subpoena,
4. to appropriate officials in health and safety emergencies,
5. for educational studies or federal or state audits, and
6. with parties to whom the school has *outsourced institutional services or functions*.¹²

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