Student: _____ **DIABETES QUESTIONNAIRE**

DOB:_____ **Student ID #:** _____

School: _____

Grade:_____ **Room:** _____ **School year:**_____

Complete & return to the School Nurse as soon as possible. The information is needed to assist your student.

Person to contact:	**Relationship:**	**Work/Cell Phone:**	**Home Phone:**
1.			
2.			

Preferred Communication method: ☐ Phone ☐ Written ☐ In Person ☐ Email: _____

Healthcare Provider Name:	**Phone:**	**Fax:**

Student is diagnosed with: ___ Type 1 ___ Type 2 Other:_____. Age at diagnosis:____

Does the student take insulin? ☐ at home ☐ at school ☐ none

Does the student wear a medical alert bracelet/necklace? ☐ Yes ☐ No

What is the student's blood glucose (BG) target range?: _____ mg/dl to _____ mg/dl

Does the student check their BG? ☐ at home ☐ at school ☐ none

(Completed Medical Management Plan with medication orders is required from healthcare provider)

When does the student check BG at home:
☐ Before each meal
☐ With symptoms of high BG
☐ With symptoms of low BG
☐ **Before physical activity**
☐ After physical activity
☐ Other:_____

Does the student test urine for ketones? ☐ at home ☐ at school ☐ none

If yes, when does the student check for urine ketones? When BG is greater than _____.

What BG level is considered low for the student? below_____ What has been their lowest BG? _____

Has the student ever needed Glucagon ☐ Yes ☐ No

How often does the student typically experience low BG?
☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

When does the student typically have a low BG:
☐ mid A.M. ☐ before lunch ☐ afternoon ☐ not often ☐ after exercise ☐ Other:_____

If the student takes the bus, how long is their bus ride? _____

Please check the student's usual signs/symptoms of low blood glucose:

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

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

How are low BG levels treated at home? Be specific. State amount of food, beverage, Glucagon, etc. :

_____

Does the student need daily snacks at school? ☐ Yes ☐ No If yes, what and when:_____

_____ **All SNACKS AND SUPPLIES used at school MUST be provided by the family.**

What would you like done about birthday treats and/or party snacks? _____

In the past year, how often has the student been treated for **severe low** BG? _____ times.
In the past year, how often has the student been treated for **severe high** BG or ketoacidosis? _____ times.

In the past year, has the student been seen for diabetes care:
☐ In the emergency room ☐ Overnight in the hospital NOTES/COMMENTS:

_____

Please Indicate the student's skill level for the following:

Skill	Does alone	Adult help	Adult performs	Comments
Checks blood glucose				
Reads meter and records				
Counts carbs for meals/snack				
Calculate carb & correction dose				
Determines total insulin dose				
Interpret sliding scale/if has one				
Draw up/dial insulin dose				
Selects insulin injection site				
Gives insulin injection				
Checks urine ketones				
Pump skills				

Does the student use an insulin to carbohydrate ratio with meals at home? ☐ Yes: ☐ No Ratio: _____

Does the student use an insulin adjustment for high or low BG at home? ☐ Yes: ☐ No

Insulin routine at home, if applicable:

Name of Insulin	Units or Ratio:	Time:

Typical carbs at:
Breakfast -
Lunch -
Dinner -
Other -
Other -

Circle method:
Pen
Syringe/vial
Pump

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 side effects of the student's medications that may affect their learning and/or behavior.:

A Diabetes Medical Management Plan and medication orders from the student's healthcare provider must be completed yearly to document updates and prescribed care. The healthcare provider may authorize self-administration of medication if the student is deemed capable. ALL insulin, medication and supplies needed at school MUST be brought to school by the family. The medication must be in the original labeled

What action do you want school staff to take if the student does not respond to treatment/medication?

Is the student compliant with their diabetes medical management at home? ☐ Yes ☐ No ☐ Sometimes

Comments: _____

Has the student received diabetes education? ☐ Yes ☐ No If Yes, where: (check all that apply)

☐ by healthcare provider ☐ at support group ☐ community agency _____

☐ at camp ☐ other _____

Please add anything else that you would like school personnel to know about the student's diabetes (or any health related condition).

Information was provided by _____ _____ _____

Name Relationship to Student Date

I authorize reciprocal release of information related to the students diabetes between the school nurse and the healthcare provider.

_____ _____

Parent/Guardian Signature Date