WARREN CONSOLIDATED SCHOOLS

Student: _____

Grade: _____ Teacher: _____

School: _____

School Phone: _____

School Fax: _____

DIABETES PARENT QUESTIONNAIRE

PARENT

I give consent to the release of information to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I also authorize reciprocal release of information related to diabetes mellitus between the school nurse and the health care provider.

My child's health information may be shared with appropriate school staff. Yes ____ No ____ (parent/guardian initials)

Student Name: _____ Date of Birth: _____

Physician/HCP Name: _____ Phone: _____

Hospital: _____ Diabetes: Type 1 ☐ Type 2 ☐

Parent/Guardian: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

SUPPLIES: PROVIDED BY PARENT/KEPT AT SCHOOL			
☐	Monitoring Equipment: monitor, test strips, lancets, lancet device	☐	Insulin Supplies: insulin, insulin pen, needles
☐	Glucose Tablets or Gel	☐	Ketone Test Strips
☐	Glucagon Kit	☐	Snacks: water, juice, peanut butter crackers, etc.

Parent will assume the responsibility for the safe delivery of equipment and medication to and from school.

Comments:

BLOOD GLUCOSE TESTING	
Target range for blood glucose: _____ mg/dl to _____ mg/dl	Type of blood glucose monitor: _____
Usual Times to Test Blood Glucose: CIRCLE YES OR NO	Can student perform blood glucose test independently?
Before Breakfast: YES / NO After Breakfast: YES / NO	Yes / Yes with supervision / No
Before Lunch: YES / NO After Lunch: YES / NO	Times to do extra tests:
Prior to Dismissal: YES / NO	Before Exercise ☐ After Exercise ☐

Comments:

INSULIN INJECTIONS IN SCHOOL

Which device does your student use: Syringe☐ Insulin Pen ☐ Pump ☐ ***If your student uses a pump, go to the next section.***

Insulin Given During School - See Dr. Orders

Before Breakfast: YES / NO After Breakfast: YES / NO	Before Lunch: YES / NO After Lunch: YES / NO
Breakfast Insulin/Carbhohydrate ratio: _____ *Correction Factor:* _____ Sliding Scale (please attach copy)	Lunch Insulin/Carbhohydrate ratio: _____ Correction Factor: _____ Sliding Scale (please attach copy)

My child has the maturity and ability to give own injection? Yes / Yes with supervision / No

My child has the maturity and ability to determine correct amount of insulin? Yes / Yes with supervision / No

My child has the maturity and ability to draw up and inject the correct dose of insulin? Yes / Yes with supervision / No

Comments:

ALL CHANGES IN INUSLIN DOSAGE MUST BE PROVIDED BY THE PARENT/GUARDIAN IN WRITING, SIGNED & DATED!

TURN OVER

STUDENTS WITH INSULIN PUMPS
Type of Pump: _____ Insulin/Carbohydrate ratio: _____ Correction Factor: _____
Is student competent regarding pump operation? Yes / Yes with supervision / No
Can student troubleshoot problems (pump malfunction)? Yes / No
Comments:
SNACKS NEEDED AT SCHOOL: YES OR NO ***If yes, please provide time & snack to be given***
AM Snack: NO / YES Snack: _____ Time: _____
PM Snack: NO / YES Snack: _____ Time: _____
Instructions for class functions (example: class parties):
Comments:
It is the parent/guardian's responsibility to provide all blood sugar correction snacks.
EXERCISE AND SPORTS
Restrictions on activity? NO / YES If yes, explain:
Student should not exercise if blood sugar is below _____ mg/dl or above _____ mg/dl.
Snack BEFORE exercise/gym? NO / YES If yes, explain:
Snack AFTER exercise/gym? NO / YES If yes, explain:
Comments:
HYPOGLYCEMIA (LOW BLOOD SUGAR)
Usual symptoms of hypoglycemia:
Treatment of hypoglycemia (see Dr.orders):
HYPERGLYCEMIA (HIGH BLOOD SUGAR)
Usual symptoms of hyperglycemia:
Treatment of hyperglycemia (see Dr. orders):
When to check for urine ketones (see Dr. orders):
Treatment for ketones (see Dr. orders):

TURN OVER