Diabetes Assessment Questionnaire – TO BE COMPLETED BY PARENT(S)

As a parent of a student with diabetes, you are well aware of the seriousness of this condition and the impact it can have on learning. Because each diabetic student functions differently, and provides self-care on an individual basis, I am requesting that you complete the following parent assessment and return it to the School Nurse as soon as possible.

It is recommended that students check in with the clinic at least once per day, typically during lunch. Please advise (by circling) as to what times you would like your student to report to the clinic:

Before school During Lunch Before driving home Other:_____

Does clinic staff need to physically observe your student's blood sugar readings on his/her monitor? **YES** **NO**

Does clinic staff need to physically observe your student drawing up insulin (via syringe, pen, pump)? **YES** **NO**

Does clinic staff need to physically observe your student injecting insulin (via pen, syringe, pump)? **YES** **NO**

Diabetic management plans often call for parents to be notified of excessively high or low numbers. What is your preferred method of communication? Please check all that apply and provide contact information below.

_____ phone call @ _____ or _____

_____ text @ _____ or _____

_____ email @ _____ or _____

Parents often question what supplies their student will need at school. The following is a recommended list. If you choose, all supplies can be safely stored in the clinic.

Blood glucose meter
Lancet device, lancets
Insulin pump and supplies
Fast-acting source of glucose
Glucagon emergency kit
Water bottle
Blood glucose strips
Insulin vials, syringes
Insulin pen, pen needles, insulin cartridges
Snacks containing carbohydrates
Ketone strips

It is recommended that you notify clinic staff of any changes in your student's diabetic needs immediately!!!

I consent to the release of information contained in my student's Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse to communicate with my child's physician/health care provider relating to diabetes management.

Parent signature/Date:_____

School Nurse signature/Date:_____

_____**Please check here and use the backside of this form to give us any further information or details relating to your student's diabetes that you feel is important for us to know.**

Diabetes Medical Management Plan

Parent/Guardian: Please complete this section

Student's Name: _____

Date of Birth: _____ Known Allergies: _____

Grade: _____ Career Technical Program : _____

Diagnosis: □ diabetes type 1 □ diabetes type 2 Age of diabetes diagnosis: _____

Last hospitalization/ER visit for diabetes: _____ Has glucagon ever been administered? □Yes □No

CONTACT INFORMATION:

Mother/Guardian: _____

Telephone: Home _____Work_____ Cell _____

Father/Guardian: _____

Telephone: Home _____ Work_____ Cell _____

Emergency Contact: (name/relationship): _____

Telephone: Home _____Work _____Cell _____

Student's Doctor/Health Care Provider:

Name: _____

Address: _____

Telephone: _____ Emergency Number: _____

Preferred Hospital: _____

Physician: Please complete this section

BLOOD GLUCOSE MONITORING:

Target range for blood glucose is □ 70-150 □ 70-180 □ Other _____

Usual times to check blood glucose _____

Can student perform own blood glucose checks? □ Yes □ No

Exceptions: _____

Type of blood glucose meter student uses: _____

INSULIN:

Type and dosage of insulin: _____ Timing: _____

Type and dosage of insulin: _____ Timing: _____

1. Can student give own injections? □ Yes □ No

2. Can student determine correct amount of insulin? □ Yes □ No

3. Can student draw correct dose of insulin? □ Yes □ No

INSULIN CORRECTION DOSES

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

_____ units if blood glucose is _____ to _____ mg/dl

Parental authorization should be obtained before administering a correction dose for high blood glucose levels. □ Yes □ No

FOR STUDENTS WITH INSULIN PUMPS:

Type of pump: _____ Basal rates _____ 12 am to _____

_____ _____ to _____

_____ _____ to _____

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

Insulin/carbohydrate ratio: _____ Correction factor: _____

Student Pump Abilities/Skills:	Needs Assistance
Count carbohydrates	□ Yes □ No
Correct bolus 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

Student Pump Abilities/Skills:	Needs Assistance
Disconnect pump	□ Yes □ No
Reconnect pump at infusion set	□ Yes □ No
Prepare reservoir and tubing	□ Yes □ No
Troubleshoot alarms and malfunctions	□ Yes □ No
Insert infusion set	□ Yes □ No

FOR STUDENTS TAKING ORAL DIABETES MEDICATIONS

Type and dosage of medication: _____ Timing: _____

Other medications: _____ Timing: _____

Other medications: _____ Timing: _____

MEALS AND SNACKS EATEN AT SCHOOL (to be provided by parent/guardian):

Is student independent in carbohydrate calculations and management? □ Yes □ No

Other times to give snacks and content/amount: _____

Preferred snack foods: _____

Foods to avoid, if any: _____

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

_____

_____

_____

EXERCISE AND SPORTS:

Snack before exercise? □ Yes □ No

Snack after exercise? □ Yes □ No

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 level is below _____ mg/dl or above _____mg/dl or if moderate to large urine ketones are present.

HYPOGLYCEMIA (LOW BLOOD SUGAR):

Usual symptoms of hypoglycemia: _____

_____

Treatment of hypoglycemia: _____

_____

HYPERGLYCEMIA (HIGH BLOOD SUGAR):

Usual symptoms of hyperglycemia: _____

_____

Treatment of hyperglycemia: _____

_____

Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.

Treatment for ketones: _____

SUPPLIES TO BE KEPT AT SCHOOL:

_____ Blood glucose meter, blood glucose test strips, batteries for meter

_____ Lancet device, lancets, gloves, etc.

_____ Urine ketone strips

_____ Insulin vials and syringes

_____ Insulin pump and supplies

_____ Insulin pen, pen needles, insulin cartridges

_____ Fast-acting source of glucose

_____ Carbohydrate containing snack

_____ Glucagon emergency kit

ACKNOWLEDGED AND APPOVED BY:

_____ _____

Physician Signature **Date**

_____ _____

Parent/Guardian Signature **Date**

_____ _____

School Nurse Signature **Date**