



CARROLL COUNTY PUBLIC SCHOOLS

PARENT DIABETES QUESTIONNAIRE

Date _____

To the Parent(s)/Guardian(s) of _____ DOB _____ Grade _____

Please complete and return to the School Nurse.

The following information is helpful in determining any special needs. School year _____

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 time should your child's blood sugar be monitored? A.M. P.M. as needed
(Authorization by a health care provider is required.) not needed

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.

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

Does he/she recognize these 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

What is your child's latest A1C _____

Date / Result

Continued on other side

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/snack				
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? Yes No Ratio: _____
Correction factor (insulin sensitivity): _____

Does your child adjust the insulin dose for high or low blood sugar? Yes No

Other medication taken on 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.

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 school nurse and the health care provider.

Parent/Guardian _____ Date _____

Reviewed by school nurse _____ Date _____