Student Services Department
181 Encinal Avenue, Atherton, CA 94027
(650) 321-7140 Fax: (650) 292-2200

DIABETES QUESTIONNAIRE

PLEASE PRINT

Date: _____

Check Site: ☐ Heritage Oak ☐ Laurel ☐ Encinal ☐ Oak Knoll ☐ Hillview

Student: _____ DOB: _____

Teacher: _____ Grade: _____

Mother/Guardian: _____ Email: _____

Address: _____

Telephone: Cell: _____ Home: _____ Work: _____

Father/Guardian: _____ Email: _____

Address: _____

Telephone: Cell: _____ Home: _____ Work: _____

Medical Provider (for Diabetes): _____

Address: _____

Telephone: _____ Fax: _____

Other Emergency Contacts:

1. Name: _____

Telephone: Cell: _____ Home: _____ Work: _____

2. Name: _____

Telephone: Cell: _____ Home: _____ Work: _____

Age of student when diabetes diagnosed: _____ ☐ Diabetes type 1 ☐ Diabetes type 2

Does student wear a medical alert bracelet or necklace: ☐ Yes ☐ No

Does the student use a continuous glucose monitor (CGM)? ☐ Yes ☐ No

If yes, what brand? ☐ Dexcom ☐ Medtronic ☐ Other _____

Does the student use an insulin pump? ☐ Yes ☐ No

If yes, what pump brand? ☐ T-Slim (Tandem) ☐ Medtronic. ☐ Omnipod ☐ Other _____

I student does not have an insulin pump, how is insulin administered? ☐ Insulin Pen ☐ Injections via a syringe

Should student's blood sugar be checked at school? ☐ Yes ☐ No

Does student know how to check his/her blood sugar using a glucometer (finger stick)? ☐ Yes ☐ No ☐ Needs Assistance

What time should student's blood sugar be monitored? ☐ As needed ☐ Routinely _____AM _____PM
(*Please provide the school with a Diabetes Medical Management Plan from your child's physician).

Will student need routine snacks at school? ☐ Yes ☐ No (If yes, snacks to be provided by the family.)

Indicate time snack is to be provided: ☐ As needed for low blood sugar _____AM _____PM

What would you like done about party/event snacks? _____

Will student need to test his/her urine for ketones at school (if experiencing high blood sugar)? ☐ Yes ☐ No

What blood sugar level is considered low for the student (i.e., when do they "feel" low)? Below: _____

How often does student typically experience low blood sugar? ☐ Daily ☐ Weekly ☐ Monthly ☐ Not often

☐ mid AM ☐ before lunch ☐ afternoon ☐ after exercise ☐ Other: _____

Check student's usual signs/symptoms of low blood sugar:

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

Does student recognize these symptoms? ☐ Yes ☐ No ☐ Sometimes

In the past year, has student been treated for severe low blood sugar (i.e., needing to use glucagon, Baqsimi)?

☐ Yes ☐ No

Did this treatment occur: ☐ at home ☐ in the emergency room ☐ overnight in the hospital

In the past year, has this student been treated for severe high blood sugar or diabetic ketoacidosis? ☐ Yes ☐ No

Did this treatment occur: ☐ at home ☐ in the emergency room ☐ overnight in the hospital

What is usually done to treat low blood sugar at home? Be as specific as possible and state exact amount of food, beverage, glucagon, etc. _____

_____

<u>Indicate student's skill level for the following:</u>

Perform fingerstick using a glucometer: ☐ does alone ☐ does with help. ☐ done by adult Comments: _____

Reads meter and interprets result: ☐ does alone ☐ does with help ☐ done by adult Comments: _____

Counts carbs for meals/snack: ☐ does alone ☐ does with help ☐ done by adult Comments: _____

Interprets carb ratios and correction factors: ☐ does alone ☐ does with help ☐ done by adult

Comments: _____

Insulin Pump skills: ☐ does alone ☐ does with help ☐ done by adult Comments: _____

Selects insulin injection site: ☐ does alone ☐ does with help. ☐ done by adult Comments: _____

Measures insulin using syringe: ☐ does alone ☐ does with help ☐ done by adult. Comments: _____

Administers insulin: ☐ does alone ☐ does with help ☐ done by adult Comments: _____

Tests for ketones: ☐ does alone ☐ does with help ☐ done by adult Comments: _____

Insulin taken on a regular basis:

Type of insulin (Humalog, Lantus, etc.):	# of Units	Time of day	Delivery method (pen, syringe, pump)

Does student use insulin to carbohydrate ratio for insulin adjustments? ☐ Yes ☐ No Ratio: _____

Does student use insulin adjustment for high or low blood sugar (correction factor)? ☐ Yes ☐ No.

Correction: _____

Other medication taken on a regular basis (i.e., for allergies, other conditions, etc.):

Medication:	Dose	Time of day	Delivery method (mouth, injection, other)

As needed medication:	Dose	Time of day	Delivery method

Please list any known medication side effects that may affect student's learning and/or behavior: _____

If medication is to be given at school, a *Medication Authorization Form* must be completed every year. The authorized health care provider may authorize self-administration of medication is student is deemed capable. Medications must be in the original labeled container/packaging. You may want to ask the pharmacist to put medications in two containers: one for school, one for home.

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

Has student received diabetes education? ☐ Yes ☐ No ☐ by health care provider ☐ at support group

☐ at camp ☐ Other: _____

Please add anything else that you would like school personnel to know about student's diabetes or health related conditions: _____

Information on this questionnaire was provided by: _____

Print name and relationship to student

_____ _____

Parent/Caregiver Signature Date

_____ _____

Reviewed by the School Nurse – Signature Date