Arlington Heights School District 25 Diabetes Questionnaire

Student Name_______________________________________Grade/Team_________________

Please complete and return to the School Nurse.
The following information is helpful in determining any special needs. School year: _______________

Person to contact:	**Relationship:**	**Work Phone:**	**Home Phone:**
1. ________________	____________________	_____________	_______________
2. ________________	____________________	_____________	_______________

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

Health Care Provider	Clinic:	Phone:
____________________	____________________	______________________________
Hospital:	Phone:	
____________________	____________________	

Student's age at diagnosis of diabetes: ________________________________

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

Will this student need routine snacks at school? ☐ A.M. ☐ P.M. ☐ as needed
(Snacks will need to be provided by the family)
What would you like done about birthday treats and/or party snacks?

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

What time should this student's blood sugar be monitored? ☐ A.M. ☐ P.M. ☐ as needed
(Authorization by a health care provider is required.)

Does this student know how to check his/her own blood sugar? ☐ Yes ☐ No

Will this student need to test his/her urine for ketones at school? ☐ Yes ☐ No

Will this student need to test his/her blood for ketones at school? ☐ Yes ☐ No

What blood sugar level is considered low for this student? below _________________________________

How often does this student typically experience low blood sugar? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____________

This student typically experiences low blood sugar:
☐ mid A.M. ☐ before lunch ☐ afternoon ☐ after exercise ☐ other _____________

Please check your student'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 signs/symptoms? ☐ Yes ☐ No

In the past year, how often has this student 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 this student 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 ☐

Adapted with permission from National Association of School Nurses H.A.N.D.S. SM, 2008

Arlington Heights District 25 Diabetes Questionnaire

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 for insulin adjustments? Yes ☐ No ☐ Ratio: ____________

Does your child use an insulin adjustment for high or low blood sugar? Yes ☐ No ☐ Dose: ____________

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 this student'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.

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

____

____

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 this student 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 this student'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

Adapted with permission from National Association of School Nurses H.A.N.D.S. SM, 2008