

Saint Thomas Academy
Parent/Guardian Diabetes Questionnaire

To maximize your child's educational opportunities while maintaining optimal diabetes management requires accurate information and good communication with everyone involved—the student, parent/guardian, health professionals, school nurse and other school personnel. Please fill out and return this questionnaire to your school nurse as soon as possible.

Student Name: _____ Grade: _____ DOB: _____

Parent/Guardian: _____ Home Phone Number: _____

Work Number: _____ Cell/Pager Number: _____

Where does your child receive his diabetes care (Name of Clinic): _____

Name of Physician: _____ Clinic Phone Number: _____

1. Age at diagnosis was: _____
2. The most recent A1C is the lab value for blood glucose control during the previous six weeks to three months. Ranges are 7-8 (good), 9-10 (fair), 11+ (poor).
3. How often does your child see a physician for blood glucose evaluation? _____
4. Has your child and/or parent attended Diabetes Education Classes? _____
5. If yes, who attended, where and when? _____

Equipment and Supplies
Provided by Parent/Guardian

Blood Glucose Meter Kit

Includes meter, testing strips, lancing device with lancet, cotton balls, spot Band-Aids

Type of Meter: _____

Low Blood Glucose Supplies (5 day supply—**please label with your child's name**) Please send appropriate supplies:

- ✓ Fast Acting Carbohydrate Drinks: (Apple juice and/or orange juice, sugared soda pop (NOT diet) at least six containers)
- ✓ Glucose Tablets, one package or more
- ✓ Glucose Gel Products, Two or more
- ✓ Other—please specify

High Blood Glucose Supplies—Please send appropriate supplies:

- ✓ Ketone Test Strips/Bottle
- ✓ Urine Cup
- ✓ Water Bottle

Insulin Supplies—Please send appropriate supplies:

- ✓ Insulin Pen
- ✓ Insulin and Syringes
- ✓ Extra pump supplies: Please specify: _____

Daily Routines

Please read and complete as appropriate

Daily Snacks: Time(s) _____
_____ Kept in health office _____ Done independently
_____ Kept in classroom _____ Needs reminder
_____ Needs daily compliance verification

Daily Blood Test: Time(s) _____
_____ Done independently
_____ Needs Assistance (specify)

Target range for blood glucose: _____ MG/DL to _____ MG/DL

Exercise: None if blood glucose test results are below _____ MG/DL

Insulin at home: Brand name and type: _____

Insulin at school: _____ Not at this time _____ Yes _____ Other

If Insulin at school: Brand Name and Type: _____

Time: _____ A new Insulin bottle every 30 days once vial is opened is recommended.

Is student able to administer insulin independently?
_____ Yes _____ No _____ Requires assistance

Hypoglycemia (Low Blood Sugar)

Please check 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
_____ Tachycardia	_____ impaired vision	_____ seizure activity
_____ Pale	_____ anxious	_____ other

Does your child recognize these symptoms? _____ Yes _____ No

Does your child have a history of severe hypoglycemia? _____ Yes _____ No

Glucagon Kit at school: _____ Yes _____ No

Hyperglycemia (High Blood Sugar)

Please check usual signs/symptoms of high blood sugar:

_____ Thirst	_____ blurred vision	_____ behavior changes
_____ Frequent urination	_____ drowsiness	_____ dry skin
_____ Fatigue	_____ nausea/vomiting	_____ other

Does your child recognize these symptoms? _____ Yes _____ No

Hyperglycemia treatment at school: _____

What concerns or questions do you have about your child's diabetes management while at school?

Information pertinent to student safety will be shared with appropriate school personnel.

Parent/Guardian Signature: _____

Feel free to call the school nurse with any concerns or questions.

Nurse Name: _____ Phone: _____