Hempfield School District
Landisville, Pennsylvania
**Diabetes Questionnaire**

**Student:** _____ **DOB:** _____ **Teacher:** _____**Grade:** _____

**Name of Physician treating diabetes:** _____ **Phone #:** _____

1. **INSULIN ADMINISTRATION**:

| | | |
|---|---|---|
| Student can draw up or dial correct dose of Insulin | ☐Yes | ☐No |
| Student can give own Insulin injections | ☐Yes | ☐No |
| Student requires nurse supervision when giving own Insulin | ☐Yes | ☐No |
| Student requires administration of Insulin by school nurse | ☐Yes | ☐No |
| Student has sliding scale in place | ☐Yes | ☐No |
| Student wears an Insulin Pump | ☐Yes | ☐No |

If blood sugar is _____ DO NOT give scheduled insulin
a. _____ Call doctor for orders
b. _____ Notify parents

2. **BLOOD GLUCOSE MONITORING**
Times: _____
Notify parents if blood sugar is above _____ or below_____.
Notify physician if blood sugar is above _____or below_____.

3. **KETONE CHECKS:** Urine ketones should be checked under the following circumstances: _____
_____

4. **POSSIBLE SYMPTOMS OF HYPERGLYCEMIA** (high blood sugar).
Parent please check the symptoms most commonly experienced by your child:

| | | |
|---|---|---|
| _____ extreme thirst | _____ frequent urination | _____drowsiness |
| _____ hunger | _____ blurred vision | _____other (specify) _____ |
| _____ nausea | _____ dry skin | |

5. **POSSIBLE SYMPTOMS OF HYPOGLYCEMIA** (low blood sugar/Insulin reaction):
Parent please check the symptoms most commonly experienced by your child:

| | | |
|---|---|---|
| _____ shaking | _____ fast heart rate | _____ sweating |
| _____ anxious | _____ dizzy | _____ hungry |
| _____ headache | _____ irritable | _____ impaired vision |
| _____ tired | _____ cold, clammy skin | _____ yawning |

**IF CHILD IS CONSCIOUS AND ABLE TO COOPERATE, PROCEED AS FOLLOWS:**
_____ Check blood sugar.
_____ If blood sugar is _____.
_____ Provide snacks (which are provided by parent/guardian)
_____ Amount of carbohydrate grams for snack are _____.
_____ Recheck blood sugar _____minutes after snack.
_____ If symptoms persist_____
_____

**IF CHILD IS UNCONSCIOUS:**
CALL 911
Administer glucagon per physician's order. **(physician to complete medication authorization form for administration of glucagon).**
NOTIFY PARENTS IMMEDIATELY
Additional instructions: _____
_____

Please **COMPLETE** the **REVERSE SIDE** of this form

6. **FOR STUDENTS WITH INSULIN PUMPS:**

Type of PUMP and Insulin IN Pump: _____

Type of infusion set: _____

Basal rates: _____ Insulin/carbohydrate ratio: _____ Correction factor: _____

| ***Student Pump Abilities/Skills*** | ***Needs Assistance*** |
|---|---|
| Count Carbohydrates | ☐ Yes ☐ No |
| Bolus correct 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 |
| Disconnect pump | ☐ Yes ☐ No |
| Reconnect pump at infusion set | ☐ Yes ☐ No |
| Prepare reservoir and tubing | ☐ Yes ☐ No |
| Insert infusion set | ☐ Yes ☐ No |
| Troubleshoot alarms and malfunctions | ☐ Yes ☐ No |

7. **DIET:**

_____ Student requires morning snack, Time: _____, Food: _____

**The parent provides snack to the school**

_____ Student requires afternoon snack, Time: _____, Food: _____

**The parent provides snack to the school**

Special instructions: _____

_____

8. **EXERCISE:**

_____ No restrictions

_____ Restrictions: DO NOT EXERCISE IF BLOOD SUGAR IS ABOVE _____OR BELOW_____

_____ Additional Instructions: _____

_____

9. **ADDITIONAL INSTRUCTIONS:** _____

_____

_____

**You are encouraged to alert all other school personnel (transportation department, child nutrition department, etc.) that may have contact with your child, so that they are aware of your child's diagnosis and the treatment that may be required during school hours.**

**Parent signature:** _____ **Date:** _____