Walla Walla Public Schools

Health Services
614 S. 3rd Ave. Walla Walla WA 99362 • PH 509.526.8507

Diabetes Questionnaire

Parents/Guardians please complete & return to the School Nurse as soon as possible. The information is needed to better assist your child.

Student: ____ DOB: _________________

School: ____

Grade: _______________ School Year: _____________

Person to Contact:	Relationship:	Work/Cell Phone:	Home:
1. _________________________	___________________	____________________	________________
2. _________________________	___________________	____________________	________________

Preferred Communication Method: ☐phone ☐written ☐in person ☐email:_______________________________

Healthcare Provider Name:	Phone:	Fax:
______________________________________	__________________________	_______________________

Student is diagnosed with: ☐ Type 1 ☐ Type 2 Other:______________ Age at diagnosis:_______

Does the student take insulin: ☐ at home ☐ at school ☐ none

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

What is the student's blood glucose (BG) target range? ___________mg/dl to ____________

Does the student check their BG? ☐ at home ☐ at school ☐ none

(Completed Medical Management Plan with medication orders is required form healthcare provider)

When does the student check BG at home: ☐ before each meal ☐ before physical activity ☐ with symptoms of high BG ☐ After physical activity ☐ with symptoms of low BG ☐ other: ___________________

Does student test urine for ketones? ☐ at home ☐ at school ☐ none

If yes, when does student check for urine ketones? When BG is greater than _________________

What BG level is considered low for the student? Below________ What has been their lowest BG? _________

How often does the student typically experience low BG? ☐ daily ☐ weekly ☐ monthly ☐ other___________________

When does the student typically have low BG: ☐ mid AM ☐ before lunch ☐ afternoon ☐ not often ☐ after exercise ☐ other ____________________

If student takes the bus, how long is bus ride? _______________________________________

Please check the student's usual signs/symptoms of low blood glucose:

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

Does the student recognize these signs/symptoms? ☐ Yes ☐ No

How are low BG level treated at home? Be specific. State amount of food, beverage glucagon, ect.:

____

____

Does the student need daily snacks at school? ☐ Yes ☐No If yes than what and when:_____________________

<u>ALL SNACKS AND SUPPLIES used at school MUST be provided by the family.</u>

What would you like done about birthday treats and/or party snacks? ____________________________________

In the past year, how often has the student been treated for severe low BG? ______________ times

In the past year, how often has the student been treated for sever high BG? ______________ times

In the past year, has the student been seen for diabetes care: ☐ In the emergency room ☐Overnight in the hospital

Walla Walla Public Schools

Health Services
614 S. 3rd Ave. Walla Walla WA 99362 • PH 509.526.8507

NOTES/COMMENTS:____

Please indicate the student's skill level for the following:

Skill	Does alone	Adult Help	Adult performs	Comments
Checks blood glucose				
Reads meter and records				
Counts carbs for meals/snack				
Calculate carb & correction dose				
Determine total insulin dose				
Interpret sliding scale – if has one				
Draw up/dial insulin dose				
Selects insulin injection site				
Gives insulin injection				
Checks urine ketones				
Insulin pump skills				

Does the student use an insulin to carbohydrate ration with meals at home? ☐ Yes ☐No Ratio: __________

Does the student use an insulin adjustment for high or low BG at home? ☐ Yes ☐ No

Insulin routine at home. If applicable

Name of insulin:	Units or Ratio:	Time:
____________________	________________	_____________
____________________	________________	_____________
____________________	________________	_____________
____________________	________________	_____________

Typical carbs at
Breakfast -
Lunch -
Dinner -
Other-
Other -

Check Method
☐ Pen ☐Syringe/vial ☐ Pump

Other medication taken on a regular basis:

Name By (mouth, injection, ect.) Dose Time of day

____

____

As needed medication:

Name By (mouth, injection, ect.) Dose Time of day

____

____

Please list side effects of the student's medication that may affect their learning and/or behavior:

A Diabetes Medical Management Plan and medication orders from the student's healthcare provider must be completed yearly. ALL insulin, medication and diabetes related supplies MUST be brought to the school by the family; for health and safety reasons, a student cannot attend school without them. All medication must be in the original labeled container.

What action do you want school staff to take is the student does not respond to treatment/medication?

____

Is the student compliant with their diabetes medical management at home? ☐ Yes ☐No

Comments:

____

Has the student received diabetes education? ☐ Yes ☐No If yes by who? __________________________

Please add anything else you would like school personnel to know about the student's diabetes (or any health condition).

____

Information provided by ______________________ ______________________ ____________

Name (Print) Relationship to Student Date

I authorize reciprocal release of information related to the student's diabetes between the school nurse and the healthcare provider.

____ ________________________________

Parent/Guardian Signature Date