

School District of Springfield Township

Diabetes Health History Form

Student's Name: _____ Date of Birth: _____

Grade: _____ Homeroom Teacher: _____

Parent/Guardian: _____ Preferred daytime phone number: _____

Parent/Guardian: _____ Preferred daytime phone number: _____

Primary Healthcare Provider: _____ Phone: _____

Endocrinologist: _____ Phone: _____

Date of Diabetes Diagnosis: _____ type 1 type 2 Other _____

How often is your child seen by the endocrinologist? _____ Most recent A1C value _____

Diabetes classes or camps attended: _____

Student's feelings about having diabetes: _____

Blood Glucose Monitoring

1. Target range of blood glucose: 70-130 mg/dL 70-180 mg/dL Other: _____

2. How often does your child check their blood glucose level at school (medical orders required):

Before lunch

After PE

___ Hours after lunch

Before dismissal

2 hrs after a correction dose

As needed for signs/symptoms of low or high blood glucose

Mid-morning

As needed for signs/symptoms of illness

Before PE

Other: _____

3. Preferred site of testing: Fingertip* Other: _____

4. Brand/Model of blood glucose meter: _____

**Note: The fingertip should always be used to check blood glucose level if hypoglycemia is suspected.*

5. Student's self-care blood glucose checking skills:

Independently checks own blood glucose

May check blood glucose with supervision

Requires school nurse to check blood glucose

6. Continuous Glucose Monitor (CGM)*: Yes No

Brand/Model: _____ Alarms set for: _____ (low) and _____ (high)

**Note: Confirm CGM results with blood glucose meter check before taking action on sensor blood glucose level.*

If student has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM

7. By what method and how often do you prefer to be notified of your child's in school blood sugar results: _____

Hypoglycemia

1. How often does your child typically experience low blood sugars? _____

Mild once a day once a week once a month

Severe (i.e. unconscious, unable to swallow, seizure, or needed Glucagon)

Include date(s) of recent episode(s) _____

2. When does he/she typically experience low blood sugars? _____

3. Please check your child's usual signs/symptoms of low blood sugars:

<input type="checkbox"/> Hunger/"butterfly feeling"	<input type="checkbox"/> Irritable	<input type="checkbox"/> Difficulty with speech
<input type="checkbox"/> Shaky/trembling	<input type="checkbox"/> Weak/drowsy	<input type="checkbox"/> Difficulty with coordination
<input type="checkbox"/> Dizzy	<input type="checkbox"/> Inappropriate crying or laughing	<input type="checkbox"/> Confused/disoriented
<input type="checkbox"/> Sweaty	<input type="checkbox"/> Severe headache	<input type="checkbox"/> Loss of consciousness
<input type="checkbox"/> Rapid heartbeat	<input type="checkbox"/> Impaired vision	<input type="checkbox"/> Seizure activity
<input type="checkbox"/> Pale	<input type="checkbox"/> Anxious	<input type="checkbox"/> Other: _____

4. Does he/she recognize these symptoms? _____

5. What do you usually do to treat low blood sugar at home? Please be specific and state amount of food, beverage, glucagon, etc. _____

Hyperglycemia

1. Please check your child's signs/symptoms of high blood sugars:

<input type="checkbox"/> Thirst/dry mouth	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Increased urination	<input type="checkbox"/> Severe Abdominal Pain	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Change in appetite/nausea	<input type="checkbox"/> Fruity breath	<input type="checkbox"/> Increasing sleepiness
<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Depressed level of consciousness
		<input type="checkbox"/> Other: _____

How do you usually treat hyperglycemia at home? _____

In the past year, how often has your child been treated for severe high blood sugar or diabetic ketoacidosis?

Insulin therapy

1. What type of insulin is administered at home:

Name	Type	Units	Time of Day	Delivery Method (Pen, Syringe, Pump)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. Will insulin administration be required at school? _____

3. Please indicate insulin delivery device: vial and syringe insulin pen insulin pump

4. Student's self-care administration skill

- Yes No Independently calculates and gives own injections
- Yes No May calculate/give own injections with supervision
- Yes No Requires school nurse to calculate/give injections

Additional information for students with insulin pump

1. Brand/Model of pump: _____ Type of insulin in pump: _____
2. Basal rates during school: _____
3. Type of infusion set: _____
4. Student's self-care pump skills: Independent?

Count carbohydrates	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bolus correct amount for carbohydrates consumed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Calculate and administer correction bolus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Change batteries	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disconnect pump	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reconnect pump to infusion set	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prepare reservoir and tubing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Insert infusion set	<input type="checkbox"/> Yes <input type="checkbox"/> No
Troubleshoot alarms and malfunctions	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other Medications (Daily and as needed)

Name: _____ Dose: _____ Route: _____ Times given: _____
 Name: _____ Dose: _____ Route: _____ Times given: _____

Meal Plan

1. Please indicate child's routine meal schedule and required snacks, if any:

<u>Meal/Snack</u>	<u>Time</u>	<u>Carbohydrate Content (grams)</u>
Breakfast	_____	_____ to _____
Mid-morning snack?	_____	_____ to _____
Lunch	_____	_____ to _____
Mid-afternoon snack?	_____	_____ to _____
Before Exercise?	_____	_____ to _____
After Exercise?	_____	_____ to _____

Other times to give snacks and content/amount: _____

Extra food allowed: At parent/guardian's discretion At student's discretion

Instructions for when food is provided to the class (e.g., as part of a class party):

- Student will eat treat.
- Replace with parent-supplied alternative.
- Modify the treat as follows: _____
- Schedule extra insulin per prearranged plan.
- Other _____

2. Student's self-care nutrition skills:

- Yes No Independently counts carbohydrates
- Yes No May count carbohydrates with supervision
- Yes No Requires school nurse/trained diabetes personnel to count carbohydrates

Transportation

- My child does not ride the bus
- My child rides bus number _____
- My child will carry his/her emergency medications and supplies on the bus daily. (Student may carry emergency medications and supplies with special permissions, please check with your school nurse.)
- My child will not carry his/her medication/supplies daily on the bus.
- My child will always carry a source of quick acting carbohydrate with them in their backpack in case they feel that their blood sugar might be low.

Extracurricular Activities:

If your child attends school sponsored extracurricular activities, please notify the school nurse and/or the adult in charge of the activity.

Additional information:

Is there anything else you would like us to know to help assist your child at school:

Please provide the following for your child prior to the start of the school year:

1. A new set of licensed prescriber orders (required at the start of each school year) along with your signed parental consent.
2. The following medical supplies, as indicated, prior to the start of school
 - Blood glucose testing supplies: Meter, strips, lancets
 - Urine ketone testing strips
 - Quick acting source of glucose
 - Glucagon emergency kit
 - Carbohydrate containing snacks with protein
 - Insulin
 - Syringes
 - Insulin pen/supplies, if applicable
 - Pump supplies (extra cartridge, infusion sets)
 - Extra batteries (for tester, insulin pump, CGM)

Thank you for providing this information to help us provide the best care we can for your child. This information and your child's picture may be shared with school personnel who work directly with your child and when deemed necessary for your child's educational experience.

Please sign and return this form to your child's school nurse.

Parent / Guardian Signature: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____

Revised 12/5/20015

Sources: NASN (2010). H.A.N.D.S: Diabetes Questionnaire.

Accessed, 12/5/2015. <http://ndep.nih.gov/media/sample-diabetes-medical-management-plan-508.pdf>