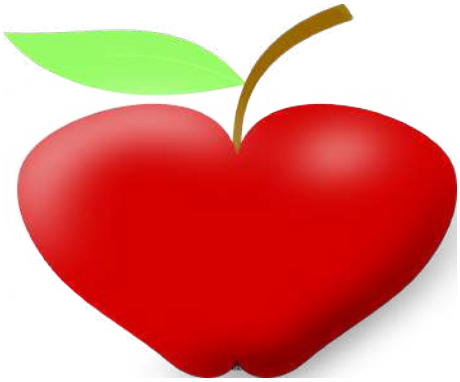

PARENT QUESTIONNAIRE FOR STUDENTS WITH DIABETES

Please complete the following information to help us better understand your child's diabetic needs while at school.

Students Name: _____

Date of Birth_____

School:_____Grade:_____

1. At what age was your child diagnosed with diabetes?_____

2. How many school days would you estimate your child missed last year due to diabetes?_____

3. How many times has your child been treated in the emergency room in the past year related to diabetes?_____

a. What situation led to the most recent emergency visit?

4. How often does your child see their diabetic health care provider for routine care?_____

5. How would you rate your child's overall diabetic status at this time? (Circle one)

Good Control
Moderate Control
Poor Control

Please provide any comments about their diabetic status:

6. What was your child's most recent A1C (hemoglobin A1c) level?_____

7. What type of insulin does your child use; please list both long and short acting versions?

8. Does your child inject insulin or have an insulin pump?

9. What type of injection system or pump do they use?

10. At what times during the day does your child routinely check their blood glucose level?

11. What type of glucose meter is used?

12. Does your child need assistance with the following activities?

Needs Assistance Checking blood glucose	Yes	No
Determining correct dose of insulin	Yes	No
Drawing up correct dose of insulin	Yes	No
Giving injections	Yes	No
Counting carbohydrates	Yes	No
Giving own bolus by pump	Yes	No
Calculating and setting basal rates	Yes	No
Disconnecting pump	Yes	No
Reconnecting pump at infusion site	Yes	No
Preparing reservoir and tubing	Yes	No
Inserting infusion set	Yes	No
Troubleshooting alarms and malfunctions	Yes	No

13. What are your child's usual symptoms when their glucose level is low?

14. What are your child's usual symptoms when their glucose level is high?

15. How would you rate your child's overall acceptance of their diabetic diagnosis? (Circle one)

Very poor Poor Average Good Very good

Comments:

16. Does your child have a hobby or participate in extracurricular activities or sports? Please list:

17. Do you feel that your child has an adequate social network of friends?

18. What are your child's typical grades?

(Circle one) Mostly A's Some A's and B's Mostly B's

Some B's and C's Mostly C's Some C's and D's Mostly D's or lower

Does not apply to grade level

Comments:

19. How often has your child had an episode of hypoglycemia where they struggled with clarity of thought and/or the ability to stay focused?

Often Occasionally Rarely Never

Comments:

20. Would you be available to attend field trips with your child? Yes or No

21. What concerns you most about your child's care this school year?

22. Other information you would like to share with the school nurse concerning your child?

I confirm by my signature that I am the parent/guardian of this student for which this information has been provided.

_____date_____

School Nurse/Reviewed by:_____date_____