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

❑ ___Hours after lunch

❑ 2 hrs after a correction dose

❑ Mid-morning

❑ Before PE

❑ After PE

❑ Before dismissal

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

❑ As needed for signs/symptoms of illness

❑ 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:

❑ Hunger/"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
❑ Rapid heartbeat	❑ Impaired vision	❑ Seizure activity
❑ Pale	❑ Anxious	❑ 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:

❑ Thirst/dry mouth	❑ Vomiting	❑ Fatigue
❑ Increased urination	❑ Severe Abdominal Pain	❑Chest pain
❑ Change in appetite/nausea	❑ Fruity breath	❑ Increasing sleepiness
❑ Blurry vision	❑ Shortness of Breath	❑ Depressed level of consciousness
		❑ 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	❑ Yes ❑ No
Bolus correct amount for carbohydrates consumed	❑ Yes ❑ No
Calculate and administer correction bolus	❑ Yes ❑ No
Change batteries	❑ Yes ❑ No
Disconnect pump	❑ Yes ❑ No
Reconnect pump to infusion set	❑ Yes ❑ No
Prepare reservoir and tubing	❑ Yes ❑ No
Insert infusion set	❑ Yes ❑ No
Troubleshoot alarms and malfunctions	❑ Yes ❑ 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:

Meal/Snack	Time	Carbohydrate Content (grams)
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