PITTSFORD CENTRAL SCHOOL DISTRICT
Parent Interview Questionnaire for Individualized Health Plan
DIABETES MELLITUS

Child’s Name ___________________________ Birthdate ________ Age ______ Grade ______
Teacher ___________________________ Information provided by ___________________________ Date ______

Please answer all questions. Use the back of this form for explanation or any additional information you feel important for us to know.

Who does your child see for regular health visits? ___________________________ Phone ________
Who does your child see for diabetes management? ___________________________ Phone ________
When was your child diagnosed with diabetes? ___________________________ at age ________

Has your child been diagnosed with any other medical conditions?
☐ No  ☐ Yes (explain) ________

Who is (are) your child’s primary caregiver(s)? ___________________________

Is (are) the primary caregiver(s) knowledgeable about the diabetic diet, symptoms of high/low glucose, effect of exercise/infection on glucose level and treatment of diabetes?  ☐ No  ☐ Yes ________

Has your child taken diabetes classes or camps?  ☐ No  ☐ Yes When? ________

Has your child been hospitalized for diabetes?  ☐ No  ☐ Yes ________
If yes, when and for what? ________

Is your child knowledgeable about his/her diet?  ☐ No  ☐ Yes ________

Does your child follow his/her prescribed diet?  ☐ No  ☐ Yes ________

How often does your child check his/her glucose each day? ________

What medications does your child take to manage his/her diabetes?

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Amount</th>
<th>When taken</th>
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Has your child been instructed on when and how to take these medications independently?  ☐ No  ☐ Yes ________

Is your child’s diabetes under good control?  ☐ No  ☐ Yes  Glucoses range from ________ to ________

Is your child aware of the symptoms/signs of low blood glucose/insulin reaction?  ☐ No  ☐ Yes ________

How would your child describe these symptoms? ________

Does your child know what to do when early insulin reaction symptoms begin?  ☐ No  ☐ Yes ________

Is your child aware of the symptoms/signs of high blood glucose/diabetic ketoacidosis?  ☐ No  ☐ Yes ________

Is your child aware of the effect of exercise on blood glucose?  ☐ No  ☐ Yes ________

Has diabetes caused your child to miss school?  ☐ No  ☐ Yes ________

What are your child’s feelings about having diabetes? ________

Is your child comfortable alerting others when experiencing problems with his/her diabetes?  ☐ No  ☐ Yes ________

Is your child participating in sports or school sponsored extracurricular activities?  ☐ No  ☐ Yes ________

Does your child carry a glucose monitoring machine, snacks, glucose tablets, glucagon when participating in sports or extracurricular activities?  ☐ No  ☐ Yes (circle all that apply) ________

Are there any barriers to management of your child’s diabetes (knowledge deficit, equipment, emotional issues/opposition to treatment, family issues, financial issues, etc.)?  ☐ No  ☐ Yes (please describe) ________

Does your child wear a “medic alert” necklace/ bracelet?  ☐ No  ☐ Yes ________

Has your physician indicated in writing that your child needs any special accommodations in school?  ☐ No  ☐ Yes (explain) ________

Comments: ________
Pittsford Central Schools
Parent Consent/Physician Authorization/Emergency Care Plan
For Management of Diabetes at School and School Sponsored Events

<table>
<thead>
<tr>
<th>Pupil:</th>
<th>School:</th>
<th>Grade:</th>
<th>DOB:</th>
</tr>
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Physician’s Written Authorization: Please initial and check all boxes that apply

1. Blood Glucose Testing
   - Before am snack
   - Before lunch
   - 2 hours after lunch
   - 2 hours after a correction dose
   - For suspected hypoglycemia
   - At student’s discretion
   - Only at student’s discretion
   - No blood glucose testing at school

2. Hypoglycemia - blood glucose less than 70: see reverse side
   - Self treatment of mild lows
   - Assistance for all lows
   - Provide extra protein & carb snack after treating lows
   - or feed snack/meal early (if scheduled within the hour)
   - OK to use glucose gel inside cheek even if unconscious
   - Glucagon injection IM (for severe hypoglycemia): __0.5 mg
     When nurse is available
     __1 mg

3. Hyperglycemia: see reverse side
   - If blood glucose >________initiate insulin administration order
   - If blood glucose >________or exhibit symptoms of ketosis, check ketones
   - Check urine ketones
   - Check blood ketones

4. Meal Plan
   - Snacks/meals: ❑ Mandatory
   - At student’s discretion
   - AM snack time: ___________
   - PM snack time: ___________
   - Lunch time: ___________
   - Other: ___________
   - Extra food allowed: ❑ Parent’s discretion
   - ❑ Student’s discretion

5. Exercise (Check and/or complete all that apply):
   - Liquid and solid carb sources must be available before, during and after all exercise.
   - Check glucose before exercise
   - No exercise if most recent blood glucose is <70 until treated as above
   - Eat ___ gms CHO for vigorous exercise:
     ❑ Before
     ❑ Every 30 minutes during
     ❑ After
   - No exercise when blood glucose is > ___ or ketones are present

6. Physician/NP Verification: Student can self-perform the following procedures (parent and school nurse must verify competency as well)
   - Blood glucose testing
   - Measuring insulin
   - Injecting insulin
   - Determining insulin dose
   - Independently operate insulin pump
   - Other ___________

7. Insulin Orders
   - Brand name and type
   - Administration times (fill in times for only those that apply):
     - Breakfast
     - AM snack
     - Lunch
     - PM snack
     - Other: ___________
   - Insulin administration via:
     - Syringe and vial
     - Insulin pump
     - Insulin pen
     - Inhaled insulin
     - Other: ___________
   - Insulin dose determined by (Check all that apply):
     - Food/bolus doses:
     - Standard lunchtime dose: ___________
     - Insulin to carbohydrate ratio: ___________
     - # unit(s) insulin per _______ gms Carbohydrate
   - Correction Calculation (complete only those that apply):
     - Give _____unit(s) for every _____mg/dl above _____mg/dl
     - Decrease correction by ___% unit(s) if PE or increased activity is anticipated after correction dose, or last dose was given less than 2 hours before.
   - Written sliding scale as follows:
     - Blood Glucose from ______ to ______ = ______ Units
     - Blood Glucose from ______ to ______ = ______ Units
     - Blood Glucose from ______ to ______ = ______ Units
     - Blood Glucose from ______ to ______ = ______ Units
   - Add carb calculation insulin dose and correction calculation for total insulin dose/bolus

8. Bus Transportation:
   - Blood glucose test not required prior to boarding bus
   - Test blood glucose 10 to 20 minutes before boarding bus
   - Provide 15 gm glucose source if blood glucose is<____mg/dl
   - Provide care as follows:
     - Other: ___________

Other Needs: Specify on physician stationary or prescription pad and attach.

Parent Consent for Management of Diabetes at School
I(We), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the following specialized physical health care service for Management of Diabetes in school be administered to our (my) child in accordance with state laws and regulations.
I will: 1. Provide the necessary supplies and equipment
2. Notify the school nurse if there is a change in pupil health status or attending physician
3. Notify the school nurse immediately and provide new consent for any changes in doctor’s orders
I authorize the school nurse to communicate with the physician when necessary.

Parent/Guardian Signature ________________ Print Name: ____________________ Date ____________
Home: ___________ Work: ___________ Cell: ___________ Emergency Contact: ___________ Phone: ___________

Physician Authorization for Management of Diabetes at School
My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. If changes are indicated, I will provide new written authorization (may be faxed).
Physician Signature ________________ Phone: ___________ Date ____________

Reviewed by School Nurse (Signature) ________________ Date ____________ Valid for ____________ school year

ECP:DB: 5/15/03, Revised 6/11/03, 12/15/03
**Diabetes Questionnaire**

**CAUSES**
- Too much insulin
- Missed food
- Delayed food
- Too much exercise
- Unscheduled exercise

**ONSET**
- Sudden

**Symptoms**

**MILD**
- Hunger
- Dizziness
- Irritable
- Shakiness
- Weak
- Sweaty
- Anxious
- Headache

Unable to concentrate
Numbness of lip and tongue
Other: __________________

**MODERATE**
- Sleepiness
- Erratic behavior
- Poor coordination
- Confusion
- Slurred speech

**SEVERE**
- Unable to swallow
- Combative
- Unconscious
- Seizure

**ACTION NEEDED**
- Notify School Nurse
- If possible, check glucose per plan
- But, always when in doubt

**TREAT**

**MILD**
- Provide sugar source
  - 2-3 glucose tablets or
  - 4 to 8 oz. juice or
  - 4 to 8 oz. regular soda or
  - Glucose gel product
- Wait 10 minutes
- Repeat sugar source if symptoms persist or blood glucose less than 70.
- Provide a snack of carbohydrate and protein, i.e. crackers and cheese.
- Communicate with parents.

**MODERATE**
- Provide sugar source
  - 3 glucose tablets or
  - 15 gm. Glucose gel
- Wait 10 minutes. Repeat glucose if symptoms persist or blood glucose less than 70.
- Follow with a snack of carbohydrate and protein, i.e. crackers and cheese.
- Notify parents.

**SEVERE**
- Call 911
- Provide glucose gel 15 gm.
  - inside cheek even if unconscious
- Give Glucagon, if ordered.
- Position on side
- Contact parents and school nurse

**SYMPTOMS OF HIGH BLOOD GLUCOSE (Hyperglycemia)**

**CAUSES**
- Too much food or drink
- Not enough insulin
- Illness
- Stress

**Onset**
- Gradual

**SYMPTOMS**
- Frequent urination
- Extreme thirst
- Dry skin
- Blurred vision
- Hunger
- Nausea
- Fatigue
- Poor exercise performance