

**Visitation School
Parent/Guardian Diabetes Questionnaire**

To maximize your child's educational opportunities while maintaining optimal diabetes management requires accurate information and good communication with everyone involved—the student, parent/guardian, health professionals, school nurse and other school personnel. Please fill out and return this questionnaire to your school nurse as soon as possible.

Student Name: _____ Grade: _____ DOB: _____

Parent/Guardian: _____ Home Phone Number: _____

Work Number: _____ Cell/Pager Number: _____

Where does your child receive his diabetes care (Name of Clinic): _____

Name of Physician: _____ Clinic Phone Number: _____

1. Age at diagnosis was: _____
2. The most recent A1C is the lab value for blood glucose control during the previous six weeks to three months. Ranges are 7-8 (good), 9-10 (fair), 11+ (poor).
3. How often does your child see a physician for blood glucose evaluation? _____
4. Has your child and/or parent attended Diabetes Education Classes? _____
5. If yes, who attended, where and when? _____

**Equipment and Supplies
Provided by Parent/Guardian**

Blood Glucose Meter Kit

Includes meter, testing strips, lancing device with lancet, cotton balls, spot Band-Aids

Type of Meter: _____

Low Blood Glucose Supplies (5 day supply—**please label with your child's name**) Please send appropriate supplies:

- Fast Acting Carbohydrate Drinks: (Apple juice and/or orange juice, sugared soda pop (NOT diet) at least six containers)
- Glucose Tablets, one package or more
- Glucose Gel Products, Two or more
- Other—please specify

High Blood Glucose Supplies—Please send appropriate supplies:

- Ketone Test Strips/Bottle
- Urine Cup
- Water Bottle

Insulin Supplies—Please send appropriate supplies:

- Insulin Pen
- Insulin and Syringes
- Extra pump supplies: Please specify: _____