Convent of the Visitation School

Health Office

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: _____ Date of Birth: _____ Grade : _____

Parent/Guardian Name: _____ Home phone: (_____)_____

Mother Cell phone: (_____)_____ Father Cell phone: (_____)_____

Mother Work phone: (_____)_____ Father Work phone: (_____)_____

Where does your child receive his/her diabetes care:

_____ _____

Clinic Name Physician Name

Clinic phone number: (_____)_____ Physician phone number: (_____)_____

1. Age at diagnosis was: _____
2. What is the student's most recent AIC level (**circle one**): 6 - 8 (good) 9 - 10 (fair) 11+ (poor)
   The most recent AIC is the lab value for blood glucose control during the previous six weeks to three months.
3. How often does your child see a physician for blood glucose evaluation? _____
4. Has your child and/or a parent attended Diabetes Education classes? ☐Yes ☐No

   If yes: who attended & where / when: _____

List of Required Equipment and Supplies

(to be provided by Parent/Guardian)

Blood Glucose Meter Kit (Includes meter, testing strips, lancing device with lancet, cotton balls, spot Band-Aids) Type of Meter: _____	**High Blood Glucose Supplies** • Ketone Test Strips/Bottle • Urine cup • Water bottle
Insulin Supplies • Insulin pen • Insulin and syringes • Extra pump supplies - please specify: _____	**Low Blood Glucose Supplies** (5 day supply - ***please label with your child's name***) • Fast Acting Carbohydrate Drinks – at least 6 containers (Apple juice and/or orange juice, sugared soda pop - NOT diet) • Glucose Tablets - 1 package or more • Glucose Gel Products - 2 or more • Other - please specify: _____

Convent of the Visitation School

Health Office

Diabetic Daily Routines

Please read and complete as appropriate. Return to the Health Office as soon as possible.

Student Name: _____ Date of Birth: _____ Grade : _____

Daily Snacks: Time(s): _____

Check all that apply: ❑ Kept in health office ❑ Needs Reminder ❑ Kept in classroom
❑ Needs daily compliance verification ❑ Keeps independently
❑ Remembers independently

Daily Blood Test: Time(s): _____

❑ Performed independently ❑ Needs assistance (specify): _____

Target range for blood glucose: _____ MG/DL to _____ MG/DL

Exercise: None if blood glucose test results are below _____ MG/DL

If Insulin at home: Brand name and type: _____

Insulin at school: ❑ Not at this time ❑ Yes ❑ Other: _____

*If Insulin at school: Brand Name and Type: _____
(A new Insulin bottle every 30 days, once vial is opened, is recommended)

Time: _____

*Is student able to administer insulin independently? ❑ Yes ❑ No ❑ Requires assistance

Hypoglycemia (Low Blood Sugar)

Please check the usual signs/symptoms of low blood sugar for your child:

❑ Hunger or "butterfly feeling" ❑ Irritable ❑ Difficulty with speech ❑ Shaky / Trembling
❑ Weak / Drowsy ❑ Difficulty with coordination ❑ Inappropriate crying or laughing ❑ Dizzy
❑ Confused / Disoriented ❑ Severe Headache ❑ Sweaty ❑ Loss of Consciousness
❑ Impaired Vision ❑ Pale ❑ Seizure Activity ❑ Anxious
❑ Tachycardia (excessively rapid heartbeat) ❑ Other: _____

*Does your child recognize these symptoms? ❑ Yes ❑ No
*Does your child have a history of severe hypoglycemia? ❑ Yes ❑ No
*Glucagon Kit at school? ❑ Yes ❑ No

Hyperglycemia (High Blood Sugar)

Please check the usual signs/symptoms of high blood sugar for your child:

❑ Frequent Urination ❑ Thirst ❑ Behavior Changes ❑ Blurred Vision
❑ Fatigue ❑ Drowsiness ❑ Nausea / Vomiting ❑ Dry Skin
❑ Other: _____

*Does your child recognize these symptoms? ❑ Yes ❑ No
*Hyperglycemia treatment at school: _____

What concerns or questions do you have about your child's diabetes management while at school?

_____

_____

Information pertinent to student safety will be shared with appropriate school personnel.

_____ _____ (_____)_____
Parent/Guardian Signature Date Phone Number

Form updated May 2012

Convent of the Visitation School
Health Office

School Communication and Treatment Authorization for Type 1 Diabetes
Physician Form: Page 1 of 2
(Form to be completed by your child's physician)

Student Name: _____ Date of Birth: _____ Grade : _____

Blood Glucose Monitoring

Blood Glucose Target Range: _____ - _____ mg/dl

Type of Meter: _____

Blood Glucose Testing Times: _____
(pre-meal, pre-exercise, etc.)

- ❑ PRN Blood Glucose Testing Symptom of Hypoglycemia / Hyperglycemia
- ❑ Permission to test independently (classroom)
- ❑ Supervision of testing/results
- ❑ Student will need assistance with testing and blood glucose management
- ❑ Results sent home: _____

Diabetes Medication

❑ No insulin at school - current regimen at home is:
- ❑ 3 shots per day
- ❑ 2 shots per day

Brand name and type at home: _____

❑ Insulin at school – current regimen is:
- ❑ Pumper / Humalog / Novolog
- ❑ Lantus / Humalog / Novolog

The insulin given at school is: ❑ Humalog ❑ Novolog

❑ Follow Bolus Wizard™ settings/dose calculator program in the insulin pump
- Dose calculation based on food intake and current blood glucose (see scale below)
- **Meal bolus _____ # units of insulin/carbohydrate choice (15GM)**
- **Blood glucose correction scale: _____ unit / _____ points BG is** > _____

Note: Correction bolus can be given with meals or every 3 hours if blood glucose levels are high. Insulin dose is a total of meal bolus and correction bolus.

Blood Glucose Value	Units of Insulin
Less than 100	
100 - 150	
151 - 200	
201 - 250	
251 - 300	
301 - 350	
351 - 400	
More than 400	

Device Used: ❑ Pen ❑ Pump (school policy requires pen or pump)

❑ Parent may adjust insulin doses as needed.

Note: Insulin pens expire 28 days after opening, NPH pen cartridges expire after 14 days, insulin vials expire 30 days after opening. Unopened vials/cartridges are able to be used through manufacturer expiration dates.

Type 1 Diabetes – Physician Form: Page 2 of 2

(Form to be completed by your child's physician)

My Meal Plan

15 Grams of carbohydrate = 1 carbohydrate choice

❑ Meal plan is variable

❑ Meal plan is prescribed (see below):

Breakfast - Time: _____ # carb choices = _____

Morning Snack - Time: _____ # carb choices = _____

Lunch - Time: _____ # carb choices = _____

Afternoon Snack - Time: _____ # carb choices = _____

Plan for pre-activity snacks: _____

Plan for after-school activities: _____

Hypoglycemia

Low Blood Glucose < = _____ mg/dl

Course of action:

- If able, check blood glucose.
- **Immediately** treat with 15 gm of fast-acting carbohydrate – in classroom (example: 4 oz. juice, 4 oz. REGULAR pop, 3-4 glucose tabs, 8 oz. skim milk).
  - ❑ Recheck blood glucose in 15 minutes and repeat 15 gm of carbohydrate if blood glucose remains low.
  - ❑ If it is more than 1 hour until next meal or snack, student should have another 15 gm of carbohydrate.
  - ❑ If child will be participating in additional exercise or activity before the next meal, provide an additional carbohydrate choice.
  - ❑ Notify parent if BG is low more than 2x in one week .
  - ❑ If using an insulin pump, suspend pump until BG is > _____ mg/dl

Severe Hypoglycemia

If the child is unconscious or having seizures due to low blood glucose immediately administer an injection of: Glucagon _____ mg **(glucagon emergency kit)**

- Immediately after administering the Glucagon, turn the child onto their side (vomiting is a common side effect of Glucagon).
- Notify parent and EMS (per school's protocol).

Hyperglycemia

High Blood Glucose > = _____ mg/dl

Course of action:

- High blood glucose is generally not an emergency.
- If the student is feeling ill or has persistent high blood glucose levels, urine ketones should be checked.
- If ketones are present in urine, encourage water and notify parent
- If ketones are present in urine, do not exercise to lower blood glucose.
  - ❑ If child is vomiting, notify parent.
  - ❑ Ketostix should be at school for PRN use.
  - ❑ Unlimited bathroom pass.
  - ❑ **Notify parent immediately of blood glucose > _____ mg/dl**
  - ❑ If using an insulin pump, refer to DKA Prevention Protocol for BG >300 mg/dl

Signatures for authorization of medications and diabetes procedures:

_____ _____

Print Name of Licensed Prescriber | Clinic Address/City/Zip

_____ _____ (_____)_____

Licensed Prescriber's Signature | Date | Phone Number

_____ _____

Parent/Guardian Signature | Child Signature (if applicable) or print child's name

Type 1 Diabetes – Parent Information

Diabetes Overview

Type 1 diabetes is an autoimmune disease in which the insulin producing cells of the pancreas no longer produce insulin resulting in a deficiency of insulin. The daily regimen for managing Type 1 diabetes includes blood glucose monitoring, insulin injections and management of high and low blood glucose levels.

Exercise

Exercise improves insulin sensitivity and the duration and intensity of exercise will influence blood glucose levels. To avoid hypoglycemia, the student may need to eat an additional carbohydrate snack before exercising. If a child will be exercising for more than 30-45 minutes they may need an additional carbohydrate before exercising. Do not exercise if ketones are present in urine. Communicate, with phy-ed teachers and coaches, symptoms of hypoglycemia and plan for prevention, recognition and treatment of symptoms.

Special Occasions

Class parties: Notify parent of party ahead of time, if possible.
The child should be given the same food as everyone else and notify parent of this.

Arrange for appropriate monitoring and access to supplies for field trips.

Resources for diabetes management at school

www.minnesotaschoolnurses.org

NDEP
(National Diabetes Education Program)
www.ndep.nih.gov
1-800-438-5383

Convent of the Visitation School
Health Office

Blood Glucose Monitoring in the Classroom

Memorandum to Parents

According to the American Diabetes Association, the ages at which children are able to perform self-care tasks for diabetes management are individual and variable. School personnel, parent/guardian, the student, and the health care team should agree upon the extent of diabetes self-care. When these parties agree that self-care of blood glucose monitoring in the classroom is appropriate for an individual student, the procedure must be done safely, carefully and accurately.

If self-monitoring of blood glucose levels in the classroom is not possible or is not desired, accommodations will be made to support the diabetic student in the school health office.

Visitation allows students with diabetes to self-monitor blood glucose in the classroom providing the following criteria are met:

- Written authorization by licensed prescriber, permitting self-monitoring of blood glucose in the classroom.
- Written authorization from parent/guardian, permitting self-monitoring of blood glucose in the classroom.
- A signed student agreement to follow procedure guidelines for self-monitoring of blood glucose in the classroom.
- Assessment by School Nurse to determine the student's knowledge and skills to safely manage his/her diabetes.

To assure a safe learning environment for all students, and to ensure the safety and optimal health management for the student with diabetes, the following competencies must be demonstrated by the student in order to do blood glucose testing in the classroom:

- Monitor blood glucose using proper technique;
- Record test results accurately;
- Know one's own symptoms of low blood sugar and the appropriate corrective measures;
- Plan for safe storage of equipment and snacks;
- Understand reasons to protect others from blood spills;
- Demonstrate appropriate disposal of used materials;
- Discernment of when school health personnel should be consulted.

To insure procedures are being followed, Visitation requests that the student check in with the health office staff or appropriate school officials on a daily basis.

Failure to meet any of the above criteria may result in suspension of the student's ability to self-monitor blood glucose in the classroom, as we need to assure a safe learning environment for all students.

Thank you for your time in assisting us to promote health and safety for your child.

Sincerely,
Health Office Staff
Convent of the Visitation School
651-683-1708

Convent of the Visitation School
Health Office

Self-Monitoring of Blood Glucose in the Classroom
Annual Student Agreement

In order to safely self-monitor my blood glucose in the classroom I agree to:

- Follow my prescribed health professional's management plan.
- Be responsible for maintenance checks on my personal equipment.
- Maintain an adequate supply of snacks and testing supplies.
- Do testing in a designated area of the classroom.
- Use correct blood glucose monitoring technique.
- Maintain a log of blood glucose levels.
- Notify health office staff whenever blood glucose levels are not in my target range.
- Safely dispose of used equipment.
- Not allow anyone else to use my equipment, medication, or snacks.
- Conduct self-monitoring procedures responsibly in the classroom.
- Meet with Health Office staff or other assigned school official daily (or as requested by Health Office).

In signing this agreement, I understand that permission for self-monitoring of blood glucose in the classroom may be suspended if I am unable to maintain the above safeguards. In this event, accommodation for blood glucose monitoring will be conducted in the school Health Office. I understand this agreement will be renewed at the beginning of each school year.

_____ _____ _____
Student Name – Printed Date Student Signature

I have read the student agreement, as shown above, and agree to be supportive of a plan to foster independence of diabetes management.

_____ _____ (____)_____
Parent/Guardian Signature Date Phone Number

This student has demonstrated appropriate knowledge of diabetes management and technique for blood glucose testing in the classroom.

_____ _____
Print or Type Name of Licensed Prescriber Clinic Address/City/Zip

_____ _____ (____)_____
Licensed Prescriber's Signature Date Phone Number

Form Updated May 2012