

Northport School District

History / Questionnaire for Student With Diabetes

Student name _____ Date of birth _____ Grade _____

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

2. Has your child been hospitalized for diabetes? Yes No If yes, when: _____

3. Does your child have allergies or take other medications? _____

4. How often does your child typically experience a low blood sugar reaction?

Daily _____ Weekly _____ Monthly _____ Other _____

5. My child typically experiences low blood sugar:

Mid-morning _____ Before lunch _____ Afternoon _____ After exercise _____

Other _____

6. My child's usual symptoms of low blood sugar: _____

7. My child's usual symptoms of high blood sugar: _____

8. Do you have concerns about your child being in school with diabetes? _____

9. How does your child manage his/her everyday needs for diabetes management?

• Insulin administration _____

• Blood glucose monitoring _____

• Ability to recognize EARLY signs of low and high blood sugar _____

• Nutrition (food preferences and/or dietary issues) _____

• Exercise _____

11. What other information do you want us to know in order to best help your child in school?

12. How would you and your child prefer to share information about diabetes with classmates?

Parent signature _____

Phone _____

Date _____