Parent/Guardian Questionnaire for Students with Diabetes
Coatesville Area School District

In order to give the appropriate care, we request that you complete this form and return it to the School Nurse. If there is any change in this information during the school year, please notify the school nurse <u>in writing</u>.

Name:_____ School:_____

School Year: _____ Grade: _____ Homeroom/Advisory: _____

Symptoms student experiences with LOW BLOOD SUGAR. (please check all that apply):

_____Headache _____Sleepiness

_____Hunger _____Inability to concentrate

_____Irritability _____Thickened speech

_____Weakness _____Irritability

_____Shakiness/trembling _____Personality changes

_____Poor coordination _____Other _____

Does your student recognize when they are feeling low? _____ YES _____ NO

Is your child able to give him/herself injections? _____ YES _____ NO

Is your child able to calculate dosage him/herself? _____ YES _____ NO

Pump: No _____ Yes _____ Type _____

Medication(s):

Name _____ When taken _____

Name _____ When taken _____

Name _____When taken _____

BGL Testing Time(s):_____Target Blood Sugar: _____

Sensitivity: 1 UNIT PER _____ mg/dL (one unit of insulin brings BS down how much?)

Coverage ratio for carbohydrates: 1 UNIT PER _____ CARBS

Special Instructions: _____

_____

PLEASE REFER TO THE MEDICATION POLICY/PERMISSION FORM IF MEDICATION IS NEEDED AT SCHOOL

Name of Physician _____ Phone Number_____

I understand the above information will be used in an emergency action plan for my child. I give my permission to share this plan with my child's assigned teachers and appropriate personnel.

Signature of Parent/Guardian_____ Date_____