Bridgeport 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 _____