H.A.N.D.S.℠
HELPING ADMINISTER TO THE NEEDS OF THE STUDENT WITH DIABETES IN SCHOOL

Student: _____
DOB: _____
Student ID #: _____

DIABETES QUESTIONNAIRE

Please complete and return to the School Nurse.
The following information is helpful in determining any special needs. School year: _____

Person to contact:	Relationship:	Work Phone:	Home Phone:
1.			
2.			

Preferred Communication method: ☐ Phone ☐ Written ☐ In Person ☐ Email: _____

Health Care Provider	Clinic:	Phone:

Hospital:	Phone:

Child's age at diagnosis of diabetes: _____

Does your child wear a medical alert bracelet/necklace? ☐ Yes ☐ No

Will your child need routine snacks at school? ☐ A.M. ☐ P.M. ☐ as needed
(Snacks will need to be provided by the family)
What would you like done about birthday treats and/or party snacks? _____

What time should your child's blood sugar be monitored? ☐ A.M. ☐ P.M. ☐ as needed
(Authorization by a health care provider is required.) ☐ not needed

Does your child know how to check his/her own blood sugar? ☐ Yes ☐ No

Will your child need to test his/her urine for ketones at school? ☐ Yes ☐ No

Will your child need to test his/her blood for ketones at school? ☐ Yes ☐ No

What blood sugar level is considered low for your child? below _____

How often does your child typically experience low blood sugar? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

When does he/she typically experiences low blood sugar:
☐ mid A.M. ☐ before lunch ☐ afternoon ☐ after exercise ☐ other _____

Please check your child's usual signs/symptoms of low blood sugar.

☐ hunger or "butterfly feeling"	☐ irritable	☐ difficulty with speech
☐ shaky/trembling	☐ weak/drowsy	☐ difficulty with coordination
☐ dizzy	☐ inappropriate crying or laughing	☐ confused/disoriented
☐ sweaty	☐ severe headache	☐ loss of consciousness
☐ rapid heartbeat	☐ impaired vision	☐ seizure activity
☐ pale	☐ anxious	☐ other

Does he/she recognize these signs/symptoms? ☐ Yes ☐ No

In the past year, how often has your child been treated for severe low blood sugar? _____

In a health care provider's office ☐ In the emergency room ☐ Overnight in the hospital ☐

In the past year, how often has your child been treated for severe high blood sugar or diabetic ketoacidosis? _____

In a health care provider's office ☐ In the emergency room ☐ Overnight in the hospital ☐

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What do you usually do to treat low blood sugar at home? Please be specific and state exact amount of food, beverage, glucagon, etc. (All supplies must be provided by the family if needed at school.) _____
Please indicate your child's skill level for the following:

Skill	Does alone	Does with help	Done by adult	Comments
Obtain glucose sample				
Reads meter and records				
Counts carbs for meals/snack				
Interprets sliding scale				
Selects insulin injection site				
Measures insulin				
Administers insulin				
Measures ketones				
Pump skills				

Insulin taken on a regular basis:

Name	Type	Units	Time of day	Delivery Method (Pen, syringe, pump)

Does your child use an insulin to carbohydrate ratio? Yes ☐ No ☐ Ratio: _____

Does your child adjust the insulin dose for high or low blood sugar? Yes ☐ No ☐ Correction factor (insulin sensitivity): _____

Other medication taken on regular basis:

Name	By (mouth, injection, etc)	Dose	Time of Day

As needed medication:

Name	By (mouth, injection, etc)	Dose	Time of Day

Please list any known medication side effects that may affect your child's learning and/or behavior:

If a medication is to be given at school, a medication authorization form must be completed yearly. A prescribing health professional may authorize self-administration of medication if the student is deemed capable. The medication must be in the original labeled container. When you get the prescription filled, please ask the pharmacist to put it into two containers so the student will have one for school and one for home use.

What action do you want school personnel to take if your child's does not respond to treatment/medication?

In an acute emergency, the student will be transported by paramedics to the hospital. Transportation in a non-acute situation is the responsibility of the parent/guardian. Any charges incurred are the responsibility of the parent/guardian.

Has your child received diabetes education? ☐ by health care provider ☐ at support group ☐ at camp ☐ other

Please add anything else that you would like school personnel to know about your child's diabetes (or related health conditions).

Information was provided by _____ (Name) _____ (Relationship to Student) _____ (Date)

I authorize reciprocal release of information related to diabetes mellitus between the school nurse and the health care provider.

_____ (Parent/Guardian) _____ (Date)