Ogden City School District
DIABETES MANAGEMENT QUESTIONNAIRE FOR SCHOOL

Student:	Date of Birth:	[ ] Type 1 Diabetes *or* [ ] Type 2 Diabetes
School:	Grade:	Age of Diagnosis:
Parent/Guardian:	Telephone:	Email:
Physician:	Telephone:	Fax:

STUDENT'S DIABETES SELF-MANAGEMENT ABILITIES

Blood Glucose Testing	[_] Student Independently Performs [_] Student Requires Supervision/Assistance *Please explain:* [_] Student Requires Full Assistance *Please explain:*
Treatment of Hyperglycemia	[_] Student Independently Performs [_] Student Requires Supervision/Assistance *Please explain:* [_] Student Requires Full Assistance *Please explain:*
Treatment of Hypoglycemia	[_] Student Independently Performs [_] Student Requires Supervision/Assistance *Please explain:* [_] Student Requires Full Assistance *Please explain:*
Carbohydrate Counting	[_] Student Independently Performs [_] Student Requires Supervision/Assistance *Please explain:* [_] Student Requires Full Assistance *Please explain:*
Calculating Correct Dose of Insulin (Routine Carbohydrate and Correction Dose)	[_] Student Independently Performs [_] Student Requires Supervision/Assistance *Please explain:* [_] Student Requires Full Assistance *Please explain:*
INSULIN DELIVERY (Indicate which type of insulin delivery system your student uses at school)	
[ ] Insulin by Injection *(By syringe or Pen)*	[_] Student Independently Performs [_] Student Requires Supervision/Assistance *Please explain:* [_] Student Requires Full Assistance *Please explain:*
[ ] Insulin Pump Use *(if applicable)*	[_] Student Independently Performs [_] Student Requires Supervision/Assistance *Please explain:* [_] Student Requires Full Assistance *Please explain:*

I understand that the purpose of this questionnaire is to assist the school team in determining appropriate accommodations for my student's medical needs during school time. My signature also authorizes the medical provider, named above, to review, modify, and authorize a Diabetes Medical Management Plan for school. The district nurse may have 2-way communication with the medical provider about my child's medical care at school as needed. This authorization is valid for 1 year from the date signed.

Parent Signature: _____ **Date:** _____