

Dear Parent/Guardian,

To better assist your student at school, please complete the following questionnaire regarding your student's diabetes self-management abilities. Please submit the form to the school office as soon as possible. With this information, the district nurses can start to develop a plan to assist your student with their diabetes care at school.

Diabetes Medical Management Plans *must* be updated each school year. In order to complete this plan in a timely manner, please request that your student's diabetes doctor provide the \***DIABETES MEDICATION MANAGEMENT ORDERS (DMMO)** to the District Nurse's office. It is the parent/guardian's responsibility to provide a current DMMO to the school nurse. (\*The Pediatric Endocrinology Clinic at Primary Children's Hospital will usually provide you with this form on your visit before the start of the school year. If your student goes to a different medical provider, this form can be found at <https://www.ogdensd.org/departments/student-health-2>.)

Please contact the district nurse if you have any questions.

Thank you.

Telephone: 801-737-8825

Fax: 801-737-8515

**Ogden City School District  
DIABETES MANAGEMENT QUESTIONNAIRE FOR SCHOOL**

Student:	Date of Birth:	<input type="checkbox"/> Type 1 Diabetes or <input type="checkbox"/> Type 2 Diabetes
School:	Grade:	Age of Diagnosis:
Parent/Guardian:	Telephone:	Email:
Physician:	Telephone:	Fax:

**STUDENT'S DIABETES SELF-MANAGEMENT ABILITIES**

<b>Blood Glucose Testing</b> <input type="checkbox"/> Blood glucose monitor (Finger Stick) <input type="checkbox"/> Continuous Glucose Monitor	<input type="checkbox"/> Student Independently Performs <input type="checkbox"/> Student Requires Supervision/Assistance <i>Please explain:</i> <input type="checkbox"/> Student Requires Full Assistance <i>Please explain:</i>
<b>Treatment of Hyperglycemia</b>	<input type="checkbox"/> Student Independently Performs <input type="checkbox"/> Student Requires Supervision/Assistance <i>Please explain:</i> <input type="checkbox"/> Student Requires Full Assistance <i>Please explain:</i>
<b>Treatment of Hypoglycemia</b>	<input type="checkbox"/> Student Independently Performs <input type="checkbox"/> Student Requires Supervision/Assistance <i>Please explain:</i> <input type="checkbox"/> Student Requires Full Assistance <i>Please explain:</i>
<b>Carbohydrate Counting</b>	<input type="checkbox"/> Student Independently Performs <input type="checkbox"/> Student Requires Supervision/Assistance <i>Please explain:</i> <input type="checkbox"/> Student Requires Full Assistance <i>Please explain:</i>
<b>Calculating Correct Dose of Insulin (Routine Carbohydrate and Correction Dose)</b>	<input type="checkbox"/> Student Independently Performs <input type="checkbox"/> Student Requires Supervision/Assistance <i>Please explain:</i> <input type="checkbox"/> Student Requires Full Assistance <i>Please explain:</i>

**INSULIN DELIVERY (Indicate which type of insulin delivery system your student uses at school)**

<input type="checkbox"/> <b>Insulin by Injection</b> <i>(By syringe or Pen)</i>	<input type="checkbox"/> Student Independently Performs <input type="checkbox"/> Student Requires Supervision/Assistance <i>Please explain:</i> <input type="checkbox"/> Student Requires Full Assistance <i>Please explain:</i>
<input type="checkbox"/> <b>Insulin Pump Use</b> <i>(if applicable)</i>	<input type="checkbox"/> Student Independently Performs <input type="checkbox"/> Student Requires Supervision/Assistance <i>Please explain:</i> <input type="checkbox"/> Student Requires Full Assistance <i>Please explain:</i>

*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 send the Diabetes Medication Management Orders to the district nurse and to allow 2-way communication with the medical provider about my child's medical care at school. This authorization is valid for 1 year from the date signed.*

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_