MONROE COUNTY
COMMUNITY SCHOOL CORPORATION
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School Intake Interview – Students with Diabetes (School Year: 20__-20__)

Contact Information

Student name: _____ Date of Birth _____

School _____Grade: _____ Teacher _____

Parent/Guardian 1:_____

Phone number(s): _____ Email _____

Parent/Guardian 2:_____

Phone number(s): _____ Email _____

Emergency Contact: _____

Phone number(s): _____ Email _____

Preferred form of communication: _____

Healthcare Provider Name: _____

Phone: _____ Fax number: _____

Transportation to/from school: _____

Will your child attend Before/After school care at their school: **YES** **NO**

School sponsored activities/sports: _____

Parent able to attend field trips: **YES** **NO**

Blood Sugar Monitoring

Routine testing times (circle):

before breakfast (if eaten at school) **before lunch** **before snack** **before PE** **before dismissal**

Call parent if blood sugar is below _____ or above _____

Does parent want routine blood sugar values communicated to them: **YES** **NO**

If YES:

How often should routine values be communicated to parent? **DAILY** **WEEKLY**

How should routine values be communicated? **PHONE CALL** **PRINT OUT** **EMAIL**

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Ability to Self-Care

Does your child need assistance with the following tasks?

Task	Needs Assistance:		
Performing finger stick glucose check	Yes	NO	n/a
Counting carbs	Yes	NO	n/a
Calculating correct insulin dose	Yes	NO	n/a
Giving insulin injections	Yes	NO	n/a
Checking ketones	Yes	NO	n/a
Giving insulin bolus via pump	Yes	NO	n/a
Setting basal rate on pump	Yes	NO	n/a
Disconnecting pump	Yes	NO	n/a
Reconnecting pump	Yes	NO	n/a
Preparing reservoir and tubing	Yes	NO	n/a
Inserting infusion set	Yes	NO	n/a
Troubleshooting alarms and malfunctions	Yes	NO	n/a

Student-specific symptoms

When your student's blood sugar is LOW, what symptoms do they typically have? (circle all that apply)

hungry	shaky	tired	headache	anxious
sweaty	dizzy	weakness	confusion	fast heart beat
irritable	other: _____			

When your student's blood sugar is HIGH, what symptoms do they typically have?(circle all that apply)

Hunger	frequent urination	tiredness	thirsty
Irritable	other: _____		

Insulin Administration

Time(s) insulin to be administered at school: _____

Does child give their own injections? **YES** **NO**

Insulin Type: **PUMP** **PEN** **VIAL/SYRINGE**

Student lunch time: _____

Snack time(s): _____

Recommended snacks: _____

Child may partake in class treats (circle): **YES** **NO**

Comments:

_____

_____

Physical Education

PE scheduled at: _____

Is snack needed before PE: **YES** **NO**

Recommended snacks before PE: _____

The information provided on these forms will be used to create an Individual Health Plan and Emergency Action Plan for your student.

Parent signature: _____ Date: _____

MCCSC Travel RN signature: _____ Date: _____