Pediatric Diabetes Education Classes at USF

Thank you for your interest in attending the Pediatric Diabetes Education classes at the University of South Florida Diabetes Center. We expect you will find the information helpful in managing your child's diabetes.

The classes are offered in four sessions of 2 1/2 hours each, during consecutive weeks, on Tuesdays. Your child must attend the classes with you. You are invited to bring with you others who help with your child's diabetes management. Due to limited space, you will need to tell the scheduler at the time you schedule your classes how many people, including your child, will be attending. **There may be 5 total people per family, including your child with diabetes.**

What to bring to class:

1. The enclosed assessment form, completed before the first class.

2. The blood glucose meter you are using and result records. If you do not have a meter, please contact your insurance to learn which brand of meter is covered (all classes).

3. The Wizdom Kit you should have received free from the American Diabetes Association. If you have not yet called for it, please contact Joanne Vaccaro-Kish, Coordinator of Diabetes Education and she will explain how to receive this kit. Her contact number is 813-974-5734. The kit is required for each class.

If you have not yet done so, you should confirm insurance coverage prior to the appointment date, as some insurance companies do not pay for this service.

Our program is recognized by the American Diabetes Association and meets the recommendations of the Florida Practice Guidelines for Diabetes. We appreciate that you have chosen us to be your diabetes educators and look forward to meeting with you soon.

All classes begin at 3:00 pm and end at 5:30 pm. Your appointment dates are as follows:

Class 1 _______  Class 2 _______  Class 3 _______  Class 4 _______

Sincerely,

The Diabetes Education Team
USF Diabetes Center
John I. Malone, M.D. and Anthony D. Morrison, M.D., Co-Directors
Pediatric Diabetes Education Classes
Tuesdays, 3:00 pm - 5:30 pm
Children's Medical Services Building

Classes are held on consecutive Tuesdays and must be attended in order. Ideally, it would be best to attend all four classes in one month, however sometimes this is not possible. So you can attend sessions, as your schedule permits, that is attend one session a month for four months, or two sessions in the first month and not again for a few months, or some other alternate schedule. We ask only that you schedule the classes in order, i.e. class 1, first; class 2, second; class 3, third and class 4, fourth. If you schedule a class and are unable to attend, please contact the Scheduling Department at 813-974-2201 to cancel and reschedule your class.

Reminder: Please bring blood glucose meter and log and Wizdom Kit with you to each class.

Class 1/Week 1: Assessment, Pre Test
Pathophysiology
Meds

Class 2/Week 2: Nutrition
Psychosocial/Family Issues

Class 3/Week 3: Monitoring/Pattern Management
School Issues
Acute/Sick Days
Prepregnancy Planning (if appropriate to group)
Use of Healthcare System, Resources, Med ID

Class 4/Week 4: Staying Fit/Physical Activity
Personal Care
Long Term Concerns/Complications
Goal Setting, Post Test
General Information:  
Date: _______________________________  
Physician Name: _______________________________  
Physician Address: _______________________________

Child's Name: _______________________________  
Parent/Guardian: _______________________________

Address: _______________________________  
City: _______________________________  
State: _________  
Zip: _______________

Phone: H _______________________________  
W _______________________________  
Other _______________

Date of Birth: _______________  
Age: _________  
Sex: M _______  
F _______

Ethnic Group:  
African American  
Hispanic  
Caucasian  
Asian/Oriental  
Other

School: _______________________________  
Grade: _______________________________

How do you/your child learn best?  
Discussion  
Reading materials  
Lecture  
Video/T.V.

Do you/your child have any problems with reading/learning? Y _______  
N _______  
What are they? _______________________________

Barriers?  
Visual _______________  
Hearing _______________

Diabetes History:

Type 1 _______  
Type 2 _______

Date of Diagnosis: _______________________________  
Age at Diagnosis: _______________________________

How is the diabetes managed?  
Diet only: _______  
Pills: _______  
Insulin: _______

Is there a family history of diabetes?  
Who? _______________________________  
Which type? _______________________________
Insulin: Type ___________________________ Amount ___________________________

_________________________ Amount ___________________________

When taken ___________________________ Injection Sites used: ___________________________

Storage ___________________________ Devices ___________________________

How often and when do you test your blood glucose?

_________________________________________

What meter? ___________________________ Average results ___________________________

Do you test for ketones? Y _______ N _______

If yes, did you have ketones _______ or ketoacidosis _______

If yes, how was it treated ___________________________

Do you ever have low blood glucose/hypoglycemia Y _______ N _______

If yes, time of day _______ and how do you treat it ___________________________

Do you wear medical ID? Y _______ N _______

General Health Status:
Ht: _______ Wt: _______ BP: _______ Allergies: ___________________________

Other medical conditions Other medications you take

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

How do you rate your overall health at this time?

Poor 1 2 3 4 5 6 7 8 9 10 Very Good

Most recent lab work and (if known)
HbAlc _______ Hgb _______ Hct _______ T4 _______ TSH _______

Cholesterol: _______ HDL: _______ LDL: _______ Triglycerides: _______

Does your child have a current meal plan/diet? Y _______ N _______

# of calories: _______ Any restrictions/special needs: ___________________________

Has your child’s weight changed in the past year? Y _______ N _______

If yes, Lost _______ lbs Gained _______ lbs
How often does your family eat out a week? ____________________________

What are your biggest challenges to healthy eating? ____________________________

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Meal Times:

Breakfast: _______  Mid AM snack: _______
Lunch: _______  Mid PM snack: _______
Supper: _______  Bedtime snack: _______

**Exercise Habits:**

Does your child get regular exercise/PE at school?  Y _______  N _______

Type ____________________________  How often? ____________________________

How long? ____________________________  Barriers to exercise: ____________________________

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**Risk Factors:**

Date of last eye exam: ____________________________  Results: ____________________________

Date of last urine protein test: ____________________________  Results: ____________________________

High Blood Pressure:  Y _______  N _______

Hypoglycemia:  Y _______  N _______

Frequent Infections:  Y _______  N _______

Ketoacidosis:  Y _______  N _______

Last dental exam: ____________________________  Results: ____________________________

Foot Problems:  Y _______  N _______

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**Has your child been hospitalized?**

Hospitalizations

Date: ____________________________  Reason: ____________________________

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Alcohol:  Y _______  N _______

Cigarettes:  Y _______  N _______

Recreational Drugs:  Y _______  N _______

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Diabetes Education History and Health Beliefs, Goals, Attitudes:

Previous diabetes education  Y _______  N _______

Who will attend class? ____________________________

Educational concerns, questions, goals ____________________________
Social/Emotional Aspects:

Please answer each of these questions which describe how diabetes has affected your attitudes and lifestyle.

(circle one)

I find it hard to believe that my child really has diabetes        Y       N
Paying for diabetes care is a problem                           Y       N
I have difficulty managing my child's diabetes                 Y       N
I feel unhappy/depressed because my child has diabetes         Y       N
My child seems unhappy/depressed because he/she has diabetes   Y       N
All things considered I feel satisfied with my life            Y       N
All things considered my child seems satisfied with his/her life Y       N

Does your culture influence or affect your decisions about diabetes?
Y ___________ N ___________ How ____________________________

Who would you consider your support person(s)? ________________________________

How would you rate the level of stress/tension in your life?

Low               Moderate               High               Very High

What are your stressors? ____________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

How do you cope with stress? ______________________________________
_________________________________________________________________
_________________________________________________________________

What do you see as your individual strengths to help you deal with your child's diabetes? ________________
_________________________________________________________________
_________________________________________________________________

Signature of parent/Guardian ________________________________________

Signature of educator _______________________________________________