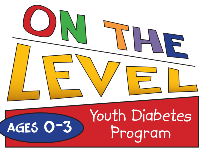


ENROLLMENT FORM

Please print clearly, answer all questions, sign and return in the enclosed business-reply envelope.

NAME OF RESPONSIBLE PARENT OR LEGAL GUARDIAN THE CHILD LIVES WITH
Last First

CHILD'S NAME
Last First

ADDRESS*
*Address should be the same as the responsible parent
Street or P.O. Box

CHILD'S DATE OF BIRTH - -
Month Day Year

CITY STATE ZIP -

CHILD'S GENDER: ❑ Female ❑ Male

YOUR GENDER: ❑ Female ❑ Male

DATE OF BIRTH - -
Month Day Year

PHONE NO. (home) - -
Area Code

E-MAIL AVAILABILITY: ❑ Yes ❑ No

HEALTH INSURANCE ID CARD NO.
(This will be your ID number for this program)

PHONE NO. (work) - -
Area Code

E-MAIL ADDRESS OF RESPONSIBLE PARENT OR LEGAL GUARDIAN**
**This is optional, but by giving us your e-mail address, you allow us to send you additional information about diabetes.

PHYSICIAN NAME
Last First

ADDRESS
Street or P.O. Box

CITY STATE ZIP -

Name of the doctor that provides your child's diabetes care ____

Have you ever worked with an Arkansas Blue Cross and Blue Shield, Health Advantage or BlueAdvantage Administrators of Arkansas registered nurse case manager?

❑ Yes ❑ No If yes, case manager's name:____

1. How long has your child had diabetes? ______ years ❑ Less than 1 year
2. What type of diabetes does your child have? ❑ Type 1 ❑ Type 2 ❑ do not know
3. Have you gone to a hospital or emergency room for your child's diabetes in the past year? ❑ Yes ❑ No
4. Check each thing that is now part of your child's diabetes treatment.
   - ❑ Food or diet plan
   - ❑ Sick day plan
   - ❑ Insulin shots or insulin pump therapy
   - ❑ Diabetes pills
   - ❑ Blood glucose testing at home and/or school
   - ❑ School or day care diabetes care plan
   - ❑ Child identification (bracelet or necklace) saying they have diabetes
   - ❑ Plan for what to do about low and high blood sugars at home
   - ❑ Other____
5. Check each item that describes your child's current status. ❑ Immunizations are current ❑ Child is protected from second-hand smoke
6. If you are a parent, do you smoke? ❑ Yes ❑ No
7. Is your child with diabetes ever in a room or car while someone is smoking? ❑ Yes ❑ No
8. If your child with diabetes is over age 10, please answer these questions:
   a. Does your child smoke? ❑ Yes ❑ No ❑ Don't know
   b. Did your child have an eye exam in the last year with drops to dilate the eye? ❑ Yes ❑ No ❑ Don't know
   c. Did your child have their feet and hands examined by a doctor in the last year? ❑ Yes ❑ No ❑ Don't know
   d. Did your child have a blood test for lipids in the last year? ❑ Yes ❑ No ❑ Don't know

(Continued on other side)

9. Please record your child's highest and lowest blood sugars in the last two weeks from your blood sugar meter.
______ Highest ______ Lowest ❑ I don't know

10. Please record your child's average blood sugar from your blood sugar meter. ______ (Example: 120) ❑ I don't know

11. Please record your child's most recent Hemoglobin A1C (HgbA1c) ______ (Example: 7) ❑ I don't know

12. What is your child's current weight? _____ pounds What is your child's current height? _____ feet _____ inches (1 foot = 12 inches)

13. In the past year, how many days of school or day care has your child missed due to any illness?
❑ 0 days ❑ 1-3 days ❑ 4-5 days ❑ more than 5 days ❑ not in school or day care

14. In the past year, how many days of school or day care has your child missed due to an illness related to diabetes?
❑ 0 days ❑ 1-3 days ❑ 4-5 days ❑ more than 5 days ❑ not in school or day care

15. How many days a week does your child exercise for at least 30 minutes?
(walking, running, playing, dancing, gymnastics, cycling, soccer, basketball, baseball, swimming, etc.)
______0 days ______1day/wk. ______3 days/wk. ______5 days/wk ______every day

16. On a scale of 1-5, how do you feel your child is adjusting to having diabetes?

1	2	3	4	5
Not adjusted		Adjusted		Very well adjusted

17. On a scale of 1-5, how do you feel you are adjusting to your child having diabetes?

1	2	3	4	5
Not adjusted		Adjusted		Very well adjusted

18. On a scale of 1-5, how do you feel your family (including all members of the family) is adjusting to having a child with diabetes?

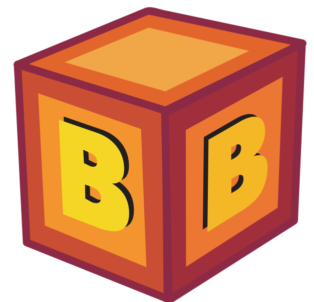
1	2	3	4	5
Not adjusted		Adjusted		Very well adjusted

19. As you take care of your child, we are very interested in supporting you with printed information.
Please list below any topics that you would like to know more about as part of the On The Level program.

____
____
____

Signature (Required): ______________________________ Date: ____________________

❑ En el futuro, me gustaría recibir correspondencia en español.



Welcome to the program!

Please note: The On The Level Youth Diabetes Education Program is for health education purposes only. We do not offer medical advice or medical services. Always consult your treating physician(s) for any medical advice or services you may need. You, as a member, are responsible for selecting providers, services or products. Please check your member benefits for coverage of services. All information furnished by you is kept strictly confidential and only used to provide us with information necessary for participation in the On The Level program.

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