

A1C Champions® Patient Information Sheet – Parent



Please call 855-A1CHAMP with any questions.

Date:

Contact Information

Name:	Your child's name:
<i>Address</i>	<i>Phone</i>
Address: City: State: Zip:	<i>Please provide all applicable numbers and check the box next to the one you would prefer we use.</i> <input type="checkbox"/> Home: <input type="checkbox"/> Cell: <input type="checkbox"/> Office: <input type="checkbox"/> Other:
<i>Email</i>	
<i>Please provide all applicable email addresses and check the box next to the one you would prefer we use.</i> <input type="checkbox"/> <input type="checkbox"/>	

Employment

Company name:	
Occupation/Vocation:	Average hours/week:
Description of daily work:	

Education

Highest level completed:	Degree(s):
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Community or Volunteer Activities

Organization(s):
Description of your involvement:

Diabetes Management

How well do you feel your child follows his/her treatment plan?	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Additional information:				
How would you rate your child's diabetes self-management abilities?	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Additional information:				
Please describe ways you help your child reduce stress in his/her life:				

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Additional Information

Are you willing and able to attend training sessions with your child? Yes No

Are you willing and able to travel (including flying) with your child for training and programs? Yes No

Do you have dependable transportation to and from your home airport? Yes No

Are you willing and able to drive you and your child to local events? Yes No

Are you willing and able to drive a rental car in locations where you and your child might travel to facilitate a program? Yes No

Do you or your child have medical equipment or devices that require additional arrangements and/or expenses when traveling? Yes No

Are you able to stand for up to one hour to facilitate a program? Yes No

Please expand on and provide additional information for above answers, as applicable:

Can you commit to participating with your child in two events in a 3-month period (some may require an overnight stay)? Yes No

Comments:

Please list any additional languages you speak:

Have you ever presented information or spoken to a group of people? Yes No
If yes, please provide an example.

Why do you want to be a mentor to parents and caregivers of children with diabetes?

Additional Comments:

Please submit Parent and Youth Patient Information Sheets together.

Email completed form to info@vprpop.com

or

Print and complete the form and return it by fax to 866-284-2035 or mail to
VPR Patient Outreach Program
801 W. 47th Street, Suite 200
Kansas City, MO 64112

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