

A1C Champions® Patient Information Sheet – Youth



Please call 855-A1CHAMP with any questions.

Date:

Contact Information

Name:		Parents' Names:	
Address:		Please provide your phone numbers and check the box next to the one you would like us to use.	
City:			
State:	Zip:	<input type="checkbox"/> Home:	<input type="checkbox"/> Cell:
Email Address:			

Education

Grade:	Favorite subjects:
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Community or Volunteer Activities

Names of groups you have volunteered for or been involved with:
Description of what you did:

Diabetes Information

<input type="checkbox"/> Type 1	Year diagnosed:	Age when diagnosed:
Additional information:		

Insulin Treatment

	Insulin Name	Date started	Date ended
What insulin do you currently use?			
What other insulin have you used before?			
Do you use an insulin pump? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when did you start using the pump:		

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Self-Management

Results of your last three A1C tests (in order from oldest to most recent):

1.	2.	3.
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Date of your last A1C test:

Additional information:

How do you feel you're doing managing your diabetes?

 Poor Average Good Excellent

Describe how you manage your diabetes:

How independent are you in managing your diabetes?

- I am able to do most everything on my own with little help from my parents.
- My parents and I equally share the responsibility of managing my diabetes.
- My parents take care of almost everything related to my diabetes care.

Additional information about how you work with your parents to manage your diabetes:

What kinds of foods do you like to eat? Give some examples of what you might have for breakfast, lunch and dinner on a normal day:

What sports and/or activities do you like to do? How does physical activity help you in managing your diabetes?

What is something in your life that can be stressful for you? What do you do when you have stress?

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Additional Information

Can you commit to participating with your parent 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 spoken to a group of people? Yes No
If yes, please provide an example.

Why do you want to help other youth 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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