Plan of Care for Diabetes

Student's Name:_____ Date of Birth:_____ Age:_____
Physician's Name:_____ Phone: _____

Allergies: List any allergies (food, meds, environmental, etc.):_____
_____

Current Insulin Treatment:
Breakfast type of insulin & dosage: _____
Lunchtime type of insulin & dosage: _____
Suppertime type of insulin & dosage: _____
Bedtime type of insulin & dosage: _____
How often are blood sugar levels checked: _____
Student will inject insulin at program: ____YES ____NO
Student will self-prepare & inject insulin at program: ____YES ____NO

Would medication(s) need to be given during normal program hours? ____YES ____NO

*If yes, a medication form must be filled out by the student's physician and returned before Your child can receive any medication. *Medication must be in original container with correct dosage instructions.*