

INDIVIDUAL PLAN OF CARE
DIABETES

Student's Name _____ School _____ Teacher _____

Mother's Name _____ (h): _____ (w): _____ (m): _____

Father's Name _____ (h): _____ (w): _____ (m): _____

Physician's Name _____ office number: _____

Medications on at home:

Glucose monitoring should take place under the following protocol:

_____ in the classroom _____ in the Health Room _____ in the office _____ other location _____

_____ in the office or Health Room when the classroom teacher is not present

_____ by the student _____ by the first aid provider or nurse

Check blood sugars at _____ am _____ pm _____ as needed

Procedure for low Blood Sugar (under _____):

_____ Give _____ for snack.

_____ For blood sugar less than _____ give _____ immediately.

_____ Call Mom/Dad if blood sugar is less than _____.

_____ Call Mom/Dad if symptoms are not relieved in 5-10 minutes.

_____ Recheck blood sugar in _____ minutes.

Procedure for high Blood Sugars (over _____):

_____ Check ketones if blood sugar is greater than _____.

_____ Encourage fluids (sugar free) and/or water.

_____ Encourage exercise.

Insulin Doses/ Sliding Scale (if necessary at school):

1.

2.

Parent's Signature

Physician's Signature

Child's Signature

Nurse's Signature