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 Child's Signature

_____ _____
Physician's Signature Nurse's Signature

_____ _____
Physician's Signature Nurse's Signature

09/02