



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.*