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

09/02

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Physician's Signature

Nurse's Signature