LEARN Resource Center

Plan of Care for Diabetes

Child'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: _____
Child will inject insulin at program: ____YES ____NO
Child will self-prepare & inject insulin at program: ____YES ____NO
Child needs assistance with injection of 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 child's physician and returned before Your child can receive any medication.

_____ _____
Parent/Guardian Signature & Date *Site Director Signature & Date*

Review of above information and signature for _____school year in LEARN.

_____ _____
Parent/Guardian Signature & Date *Site Director Signature & Date*

Review of above information and signature for _____school year in LEARN.

_____ _____
Parent/Guardian Signature & Date *Site Director Signature & Date*