

DIABETES AMENDED PLAN OF CARE FORM

STUDENT'S NAME _____ DATE _____

INSULIN RATIOS: _____ Unit(s) for every _____ grams of carbohydrates eaten,
Plus _____ unit(s) for every _____ mg/dL points above _____ mg/dL

ADDITIONAL
ADMENDMENTS _____

PARENT'S NAME _____

PARENT'S SIGNATURE _____

Attach copy to current diabetic care plan.

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