Pediatric Individualized Education Plan
Division of Endocrinology, Friedman Diabetes Institute
Diabetes Education Program
Phone: (212) 420-3450
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General Information

Name _____ Date _____
DOB _____ SS# _____
Address _____ Age _____
Emergency Contact Phone _____
Other Contact Phone _____
Primary Doctor's Contact Phone _____
Diabetes Doctor's Contact Phone _____

Diagnosis ☐ Type 1 diabetes ☐ Type 2 diabetes

Diabetes disease process

How long has the child had diabetes? _____

Other family members with diabetes:

☐ Mother ☐ Father ☐ Sibling ☐ Grandparent

Management Plan

A) Monitoring

1. How often is the child's blood sugar tested? _____
2. What time of the day is the child's blood sugar tested? _____
3. What is the child's target blood sugar range? _____
4. How do the child's blood sugar readings run throughout the day?
   Please note any that apply:

   Fasting _____
   2 hours after breakfast _____
   Pre lunch _____
   2 hours after lunch _____
   Pre dinner _____
   2 hours after dinner _____
   Bedtime _____
   3am _____

B) Medications

1. Child's medication schedule

   Does the child take insulin? _____ Oral agents? _____
   What kind (s) _____
   What time is the insulin or oral agent taken? _____
   Where is the insulin kept? _____
   Where is the insulin injected? _____
   How is the insulin given?
   ☐ Pen ☐ Vial/Syringe ☐ Insulin pump

2. Name of person responsible for administering medications/treatments to child

   _____

3. What are the diabetes related supplies which are kept at school

   _____

4. Has the child ever had a low blood sugar? _____
   How was the low blood sugar treated? _____
   Do you have glucagon at home? _____
   Does someone in the house know how to give it to the child? _____
   How did the child feel when he/she had the low blood sugar reaction? _____

   _____

5. Can the child feel if he/she is having a low sugar reaction? _____

6. Has the child ever been in DKA (diabetic ketoacidosis)? _____
   Has the child ever had a sugar over 240? _____
   Is the child's ketones tested when BS is over 240? _____
   How was the high sugar treated? _____
   How did the child feel when the BS was high? _____

Meal Planning

1. Meal and snack guidelines (note times too)

   Breakfast _____ Snacks _____

   Lunch _____ Dinner _____

   Bedtime _____

2. Has the child been counseled by a dietitian before? If so, when? _____

Exercise guidelines

Does the child exercise regularly? _____

If yes, what type?

☐ walking ☐ biking ☐ chores ☐ swimming ☐ sports?

Does the child routinely participate in sport activities?

Does the child keep a source of carbohydrate with him/her while exercising?

Does the child monitor his/her blood sugar while exercising?

Chronic complications

To your knowledge, does your child have any of the following complications from diabetes?

☐ Eye disease ☐ Heart problems

☐ Kidney problems ☐ Digestive problems

☐ Numbness/pain

Please fax completed form. Thank you!

Name of Person completing form _____

Relationship to child _____

Signature _____

Date _____