

BLOOD GLUCOSE MONITORING LOG

Student Name: _____ Birth Date: _____ Bus #: _____
 Allergies: _____ Doctor's Name: _____ Contact #: _____
 Blood Glucose Target Range: _____ Parent Name(s): _____ Contact #: _____
 Correction Dose/Formula: _____ Emergency Contact Name: _____ Contact #: _____
 Insulin dose for Carbohydrate intake: _____ Lunch Time: _____ PE/Health Period: _____
 Type of Pump: _____ Special Instructions: _____

Date	Time	Activity	Blood Glucose Test Results	Correction Insulin BG - _____	Carb Count	Insulin Dose for Carb Intake _____:_____	Total	Total Amount of Insulin Actually Given	Snack	Ketones	Notes	Initials of Care Provider

Nurse/Staff Signature: _____ Initials: _____
 Nurse/Staff Signature: _____ Initials: _____
 Nurse/Staff Signature: _____ Initials: _____