INSULIN BY INJECTION

NAME:		AGE:	WEIGHT _	D .	ATE:	PROGRAM:						
Does your child perform	blood glucose m	onitoring indepen	dently? Yes	No Do	Does your child give his/her own injections? \square Yes \square No							
Long-Acting Insulin Name:	Time: Amount:	Time: Amount:										
Short-Acting Insulin Name:	Time: Amount:	Time: Amount:										
Intermediate-Acting Insu	lin Name:	<u> </u>										
	Breakfast	Snack	Lunch	Snack	Dinner	Snack	Bedtime					
Blood Glucose Target												
Correction Bolus Meal Bolus												
Or slidi			<u>Iay attac</u>	ch a cop	y of what	you use at l	<u>nome)</u> :					

Blood glucose	Breakfast	Lunch	Dinner

Parent/Guardian Signature Date	
Physician's Signature Date	
On site nurse signature Date	

INSULIN PUMP

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sal ra	atec.																							
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