Cincinnati Children's Diabetes Center

Diabetes Monitoring Log for Students at School

Student's Name: _____ Address: _____ Date of Birth: _____

School Name: _____ Grade: _____

Parent(s) Name: _____ Phone: _____ Phone: _____

Type of insulin therapy: Split/Mixed___ Insulin Pump___ Basal/bolus___ **Carb ratio for food**: 1 unit for ___ grams of carbohydrates

Correction target BG: _____mg/dL **Correction factor**: 1 unit for every _____mg/dL above correction target

Insulin pen cartridge/vial change dates: _____ _____ _____ _____ _____ _____ _____ _____ _____

Date	Time	Blood Glucose	Insulin dose	Ketones (neg, S, M or L)	Comments (note any unusual circumstances, i.e. extra food intake, hypoglycemia treatment, physical activity, change in routine, illness)	Initials

Signature of staff providing care	Initials	Signature of staff providing care	Initials	Signature of staff providing care	Initials

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