

RECORD OF INSULIN ADMINISTERED VIA INSULIN PUMP
(Supervised/Administered by staff – Delete as appropriate)



Pupil's name: _____ School _____

Name of Medication _____

DATE	TIME	BLOOD GLUCOSE (BG) SENSOR GLUCOSE (S)	BLOOD KETONE RESULT (If BG > 14)	CARBOHYDRATE (GRAMS) If meal or snack	INSULIN DOSE VIA PUMP (units)	COMMENTS	STAFF NAME	SIGNATURE

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