

INSULIN BY INJECTION

NAME: _____ AGE: _____ WEIGHT _____ DATE: _____ PROGRAM: _____

Does your child perform blood glucose monitoring independently? Yes No

Does your child give his/her own injections? Yes No

Long-acting Insulin Name:	Time:	Time:					
	Amount:	Amount:					
NPH	Time:	Time:					
	Amount:	Amount:					
Short-acting Insulin Name:							
	Breakfast	Snack	Lunch	Snack	Dinner	Snack	Bedtime
Blood Glucose Target							
Correction Bolus							
Meal Bolus							

Or sliding scale below:

Blood glucose	Breakfast	Lunch	Dinner
80-100			
101-150			
151-200			
201-250			
251-300			
>300			

Long-acting Insulin name, amount, and time:

Short-acting insulin name:

