DOCUMENTATION OF STUDENT BLOOD GLUCOSE MONITORING IN THE SCHOOL SETTING

Student Name: _____ Grade: _____

Signature:_____Initial_____ Signature:_____Initial_____

DATE	TIME	INITIALS	BLOOD GLUCOSE TEST RESULT Acceptable Range For Student ( )	ACTION TAKEN	
				None Required	Contact/Insulin Dose

CONTACT NUMBERS:

SCHOOL NURSE: _____

PARENT: _____

PRIMARY CHILDREN'S MEDICAL CENTER
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