BLOOD SUGAR LEVEL/INSULIN ADMINISTRATION FORM

Name: | Month/Year: |

Allergies (food, drug, other):

Physician: | Route Code: |

Diagnosis:

Medication Name:

Medication Instructions:

Special Instructions:

Date	**Time** Blood Was Drawn	**Blood Sugar Level**	**Staff**	**Additional Amount** of Insulin Given	**Time** Additional Insulin Given	**Comments**

Initials and Name:

Date	**Time** Blood Was Drawn	**Blood Sugar Level**	**Staff**	**Additional Amount** of Insulin Given	**Time** Additional Insulin Given	**Comments**

Initials and Name:

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