ADJUSTABLE INSULIN THERAPY

(Attach to insulin medication order and place in medication book)

Student's Name: ______________________________**Date of Birth:** _______/______/______

School: ____**Teacher Grade:** ___________________

Parent/Guardian:______________________________**Phone:**___________________________

Insulin type:_____________________________

Method of delivery: ☐ syringe ☐ insulin pen ☐ insulin pump

Target Blood Glucose:____________________**Pump Basal rate (if applicable):**___________

Insulin/carbohydrate ratio for

Lunch:_____________

Carbohydrates	Insulin dose

Snacks/classroom food: ___________

Carbohydrates	Insulin dose

Blood Glucose correction ratio: ____

Blood Glucose	Insulin dose

☐ **Do not repeat correction dose if less than____________hours since last insulin dose**

Contact parent if BG is less than ____mg/dL or over ____ mg/dl or large ketones