Escambia County Public Schools
Health Services
30 E. Texar Dr.
Pensacola, FL 32503
(850) 469-5456

PARENT/GUARDIAN REQUEST FOR INSULIN ADJUSTMENT

School Year 20_____-20_____

Student Name:_____

Student ID:_____

DOB:_____

This form is to be used for the initial selection and subsequent adjustments to the Carbohydrate Ratio and/or Correction Factor

Carbohydrate Ratio and Correction Factor must be within the limits indicated by the Dr.'s orders on the DM Medical Management Form

Insulin to Carbohydrate Ratio:

Breakfast: 1 unit of insulin for every _____ grams of carbohydrates eaten

Lunch: 1 unit of insulin for every _____ grams of carbohydrates eaten

Correction Factor:

Breakfast: 1 unit of insulin for every _____ mg/dl above or below blood glucose target.

Lunch: 1 unit of insulin for every _____ mg/dl above or below blood glucose target.

Parent/Guardian Name Print	Parent/Guardian Name Sign	Date
Clinic Staff Name Print	Clinic Staff Name Sign	Date

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Created 8-11-26

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