

DOB: _____

Check Blood Glucose: Before meals/snacks, and for symptoms of high/low blood glucose. Additionally: Before PE ☐ Before Home ☐

[illegible]

Initials	Print Name	Sign Name & Title	Date	Codes for Action Taken (use all that apply)	
				IA: Insulin Administered	H: Sent home
				M: Sent to meal	S: Regular slow snack given
				E: Escorted to meal	F: Emergency fast snack given
				RTC: Returned to class	O: Out of Insulin or Testing Supplies (make note)
				C: Comment on back	911: EMS called
				N: Notified Parent/Guardian	R: Refused

Student Name:_____ **Student ID:**_____ **SY 20**____ **- 20**____

CLINIC NOTES

Don't forget to Date/Time and Sign/Title your notes