



**MIAMI-DADE COUNTY PUBLIC SCHOOLS
DAILY DIABETIC LOG**

Student's Name: _____ **ID#:** _____ **School:** _____ **Week of:** _____

Parent: _____ **Phone #:** _____ **Doctor:** _____ **Phone #:** _____ **Fax #:** _____

Diabetes Medical Management Plan/Treatment Authorization (DMMP) form: Date signed by physician: _____

Type of insulin given: _____ **Insulin delivery:** Syringe/Vial Pen Pump (for pump, give reason B= Bolus C= Correction Dose)

REMEMBER: INSULIN ADMINISTRATION ONLY AT TIMES ORDERED.

DATE	TIME	BLOOD SUGAR	# CARBS	INSULIN DOSE	SITE OF ADMINISTRATION	KETONES if above:	SIGNATURE	COMMENTS
Mon								
Mon								
Tues								
Tues								
Wed								
Wed								
Thurs								
Thurs								
Fri								
Fri								

Note: If support for carbohydrate counting is needed, refer parents to the menus and carbohydrates totals for meal planning at: <http://nutrition.dadeschools.net>.