DIABETES MANAGEMENT SHEET

Member Name:
Date of Birth:
Type of Diabetes:
Name of Doctor:

TREATMENT

Medication Name:	
Dose:	
Time:	
Notes:	

If blood sugar is below:	______ (level)	Give the following:	☐ glucose tabs ☐ juice ☐ other:
If blood sugar is below:	______ (level)	CALL:	Name: Number:
If blood sugar is above:	______ (level)	Give the following:	☐ water ☐ rest ☐ other:
If blood sugar is above:	______ (level)	CALL:	Name: Number:

I give permission for the BGC Pembroke staff to administer the above mentioned care to the member listed above. I acknowledge that it is my responsibility to advise staff of any changes regarding my child's care.

Parent Name	Parent Signature	Date