Germantown Municipal School District

Blood Glucose/ Insulin Log/Carb Count

School _____ School Year _____

Student Name: _____ Teacher _____ Grade: ____

Healthcare Provider's Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Work Phone: _____ Cell: _____

DATE	*TIME*	*BG*	*CARBS EATEN (GMS)*	*INSULIN GIVEN OR OTHER ACTION TAKEN*	*INITIALS*

School NurseSignature : _____

School NurseSignature : _____

Medical Records Clerk Signature _____

Medical Records Clerk Signature _____