Holly Area Schools

Diabetic Daily Log

Pen Expiration date:_____

School year: _____

Student Name: _____ DOB: _____ Grade: ____

School: _____ **Only trained staff may administer insulin. If administering medication, you must sign the form.**

Trained Staff Name:	Signature:	Initials

Date	Time	Blood Glucose	Grams of carbs ate	Insulin Given	High or Low Interventions	Initials	Witness Initials

4/2024

Holly Area Schools

Diabetic Daily Log

Pen Expiration date:_____

Date	Time	Blood Glucose	Grams of cabs ate	Insulin Given	High or Low Interventions	Initials	Witness Initials

4/2024

Holly Area Schools

Diabetic Daily Log

Pen Expiration date:_____