Renfrew County

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