Houston Independent School District
Health and Medical Services

Diabetes Treatment Form

School _____

Signature/Initial

_____
_____
_____

Student_____**Grade**_____**DOB** _____

Physician_____Phone Number_____Contact RN/CDE_____Phone Number_____

Parent/Guardian Name_____ Phone Number_____Contact # 2_____Phone Number _____

Doctor's Orders: Insulin Type 1._____2._____I: C Ratio_____Target Blood glucose _____

Sensitivity Factor (SF)/Correction Factor (CF)_____ Correction scale provided by physician when necessary

Date	Time	Blood glucose reading	Carbs eaten	Carb Coverage Carbs eaten ÷ I:C = **A**	Target Current Blood glucose – Target **=** **B**	Correction B ÷ CF = **C**	Insulin given **A + C =** units given	Initials	Ketone Neg, Sm, Mod, Lg	Comments (use back as needed)

Pg.____ School_____ School Nurse/UDCA _____

Student_____Grade_____DOB _____

Date	Time	Blood glucose reading	Carbs eaten	Carb Coverage Carbs eaten ÷ I:C = **A**	Target Current Blood glucose – Target **=** **B**	Correction B ÷ CF = **C**	Insulin given **A + C =** units given	Initials	Ketones Neg, Sm, Mod, Lg	Comments (Use back as needed)