Month/Year: _____

INSULIN ADMINISTRATION LOG

Client Name: _____ DOB:_____

Insulin Order(s)				
Name of Insulin (as printed on medication label)	Dose	Frequency	Blood Glucose Level Check Required (Yes or No)	Order Expiration Date

Date	Time	Name of Insulin (as printed on medication label)	Blood Glucose Level (If no, write N/A)	Units Given	Site LA- Left arm RA- Right arm ABD- Stomach	Initials (person giving med)

Month/Year: _____

Date	Time	Name of Insulin (as printed on medication label)	Blood Glucose Level (If no, write N/A)	Units Given	Site LA- Left arm RA- Right arm ABD- Stomach	Initials (person giving med)

Month/Year: _____

Date	Time	Name of Insulin (as printed on medication label)	Blood Glucose Level (If no, write N/A)	Units Given	Site LA- Left arm RA- Right arm ABD- Stomach	Initials (person giving med)

Month/Year: _____

Date	Time	Name of Insulin (as printed on medication label)	Blood Glucose Level (If no, write N/A)	Units Given	Site LA- Left arm RA- Right arm ABD- Stomach	Initials (person giving med)

Print Name	Signature	Initials	Role Medication Assistance Provider (MAP), Direct-Support Professional (D-SP), or Client's Relative