

# Blood Glucose Tracking

<b>NAME</b>		<b>MONTH/YEAR</b>	
<b>PRESCRIBING DR</b>			
<b>ALLERGIES</b>			

PCP order for frequency of \_\_\_\_\_

DAY	HOUR TAKEN						COMMENTS
1							
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31							

Each person administering/counting medications must sign and initial the spaces below

Signature: _____	Initials: _____
Signature: _____	Initials: _____
Signature: _____	Initials: _____
Signature: _____	Initials: _____
Signature: _____	Initials: _____

**AUTHORIZED ABBREVIATIONS**

- P** - Program
- V** - Visit/Vacation
- H** - Hospital
- D/C** - Discontinued