Charles H. Best Diabetes Centre for Children & Youth

Name: _____ Phone # (R): _____ Dr._____

Parent/Spouse: _____ Phone # (B): _____ Age_____ A1C_____ Dx:_____

Yr:	Breakfast		Lunch		Dinner				Insulin					
Month:	Before	After	Before	After	Before	After	Bed time	Over night	B	L	D	BED	Total Units	Notes:

Email: bloodsugars@charleshbest.com

Fax: (905) 620-0579 Phone: (905) 620-0360 Pager: (905) 720-6982