Be sure to take your medications exactly as prescribed.

Breakfast	Lunch	Dinner	Bedtime

PLEASE REMEMBER:
Bring your blood sugar log and meter to all your visits!

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Women In Control

My Action Plan and Tracker

Name: _____ Date: _____

Sample Entries

Monday - Food and Drink

Time	Food and Drink Amount/Name/Description	Carb Grams
8:00 am	1/2 cup oatmeal - unflavored	15
	1 cup 1% milk	12
	1 small banana	15

Monday - Physical Activity

Time	Type of Activity	Minutes
5:30 pm	brisk walking	30 min.
Total Number of Steps Per Day:		

My S.M.A.R.T. Weekly Action Plan

Every week, we will make an individual pledge about food, activity, medications and blood sugar. We will keep track of how well we are keeping to our Weekly Action Plan, and we will watch our progress over the weeks. Good plans have S.M.A.R.T. objectives or goals. What do I mean by S.M.A.R.T.?

S = Specific	Your goal should specify just what you want to complete for the week.
M = Measurable	You should be able to measure whether you are completing the goal or not.
A = Achievable	Your goal should be something that you can achieve.
R = Realistic	Your goal should be realistic—something that you can complete with the resources that you have (you should be able to complete it without having to buy anything new or get any additional help other than what you already have).
T = Time	You should decide when you will complete the goal. Here are a few examples of some pledges to help you see what is S.M.A.R.T. or not. Read two or three of the following action plans and ask how they could be improved.

Remember that your pledge should be realistic and specific, and it should include something that can be done regularly and become routine.

PLEASE REMEMBER:
Bring your blood sugar log and meter to all your visits!

My Weekly S.M.A.R.T. Action Plan

Name: _____ Date: _____

My goal for the week...
Goal 1:

What am I going to do:_____

Where am I going to do it and how often:_____

_____

Who will do it with me:_____

How much will I do and for how long:_____

Challenges:	**Strategies:**
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

How confident are you that you can achieve this goal?
(Please circle the number that best tells how confident you are)

1 2 3 4 5 6 7 8 9 10

1 = I am **not confident** at all that I can achieve this goal

10 = I am **completely confident** that I can achieve this goal

Day 1 Food and Drink Tracker

Day: _____ Date: _____

Time	Food and Drink Amount/Name/Description	Carb Grams

Blood Sugar (Please record 2 readings per day)	
Time:	Reading:

Day 7 Medications Tracker (continued)

Day: _____ Date: _____

Time	Name of Diabetes Medications Taken	Did you take All? Some? or None? (please circle)	Comments List any issues you had with your medications
Morning:		All Some None	
Midday:		All Some None	
Afternoon/ Evening:		All Some None	
Other:		All Some None	

Day 7 Daily Physical Activity

Time	Type of Activity	Minutes	Comments
Total Number of Steps for Today:			

Day 7 Food and Drink Tracker

Day: _____ Date: _____

Time	Food and Drink Amount/Name/Description	Carb Grams

Blood Sugar (Please record 2 readings per day)	
Time:	Reading:

Day 1 Medications Tracker (continued)

Day: _____ Date: _____

Time	Name of Diabetes Medications Taken	Did you take All? Some? or None? (please circle)	Comments List any issues you had with your medications
Morning:		All Some None	
Midday:		All Some None	
Afternoon/ Evening:		All Some None	
Other:		All Some None	

Day 1 Daily Physical Activity

Time	Type of Activity	Minutes	Comments
Total Number of Steps for Today:			

Day 2 Food and Drink Tracker

Day: _____ Date: _____

Time	Food and Drink Amount/Name/Description	Carb Grams

Blood Sugar (Please record 2 readings per day)	
Time:	Reading:

Day 6 Medications Tracker (continued)

Day: _____ Date: _____

Time	Name of Diabetes Medications Taken	Did you take All? Some? or None? (please circle)	Comments List any issues you had with your medications
Morning:		All Some None	
Midday:		All Some None	
Afternoon/ Evening:		All Some None	
Other:		All Some None	

Day 6 Daily Physical Activity

Time	Type of Activity	Minutes	Comments
Total Number of Steps for Today:			

Day 6 Food and Drink Tracker

Day: _____ Date: _____

Time	Food and Drink Amount/Name/Description	Carb Grams

Blood Sugar (Please record 2 readings per day)	
Time:	Reading:

Day 2 Medications Tracker (continued)

Day: _____ Date: _____

Time	Name of Diabetes Medications Taken	Did you take All? Some? or None? (please circle)	Comments List any issues you had with your medications
Morning:		All Some None	
Midday:		All Some None	
Afternoon/ Evening:		All Some None	
Other:		All Some None	

Day 2 Daily Physical Activity

Time	Type of Activity	Minutes	Comments
Total Number of Steps for Today:			

Day 3 Food and Drink Tracker

Day: _____ Date: _____

Time	Food and Drink Amount/Name/Description	Carb Grams

Blood Sugar (Please record 2 readings per day)	
Time:	Reading:

Day 5 Medications Tracker (continued)

Day: _____ Date: _____

Time	Name of Diabetes Medications Taken	Did you take All? Some? or None? (please circle)	Comments List any issues you had with your medications
Morning:		All Some None	
Midday:		All Some None	
Afternoon/ Evening:		All Some None	
Other:		All Some None	

Day 5 Daily Physical Activity

Time	Type of Activity	Minutes	Comments
Total Number of Steps for Today:			

Day 5 Food and Drink Tracker

Day: _____ Date: _____

Time	Food and Drink Amount/Name/Description	Carb Grams

Blood Sugar (Please record 2 readings per day)	
Time:	Reading:

Day 3 Medications Tracker (continued)

Day: _____ Date: _____

Time	Name of Diabetes Medications Taken	Did you take All? Some? or None? (please circle)	Comments List any issues you had with your medications
Morning:		All Some None	
Midday:		All Some None	
Afternoon/ Evening:		All Some None	
Other:		All Some None	

Day 3 Daily Physical Activity

Time	Type of Activity	Minutes	Comments
Total Number of Steps for Today:			

Day 4 Food and Drink Tracker

Day: _____ Date: _____

Time	Food and Drink Amount/Name/Description	Carb Grams

Blood Sugar (Please record 2 readings per day)	
Time:	Reading:

Day 4 Medications Tracker (continued)

Day: _____ Date: _____

Time	Name of Diabetes Medications Taken	Did you take All? Some? or None? (please circle)	Comments List any issues you had with your medications
Morning:		All Some None	
Midday:		All Some None	
Afternoon/ Evening:		All Some None	
Other:		All Some None	

Day 4 Daily Physical Activity

Time	Type of Activity	Minutes	Comments
Total Number of Steps for Today:			