INSULIN BY INJECTION

NAME: _____**AGE:** _____ **WEIGHT** _____ **DATE:** _____ **PROGRAM:** _____

Does your child perform blood glucose monitoring independently? ☐ Yes ☐ No **Does your child give his/her own injections**? ☐ Yes ☐ No

Long-Acting Insulin Name:	Time: Amount:	Time: Amount:	[redacted]				
Short-Acting Insulin Name:	Time: Amount:	Time: Amount:					
Intermediate-Acting Insulin Name:							
[redacted]	Breakfast	Snack	Lunch	Snack	Dinner	Snack	Bedtime
Blood Glucose Target							
Correction Bolus							
Meal Bolus							

Or sliding scale below (May attach a copy of what you use at home):

Blood glucose	Breakfast	Lunch	Dinner

Long-Acting Insulin name, amount, and time:

Short-Acting Insulin name:

INSULIN PUMP

***NAME :*_____ *AGE:* _____ *WEIGHT:* _____ *PUMP START DATE:*_____**
PUMP TYPE: _____ **INSULIN**: _____

Camper can change own infusion set: YES □ NO □ Partial □ **Camper can draw up cartridge of insulin**: YES □ NO □ uses pre-filled □
Have you changed the home dose to the camp dose? YES □ NO □
Date of last site change*:* _____ Infusion set used*:* _____

Basal rates:

12	1a	2a	3a	4a	5a	6a	7a	8a	9a	10a	11a	12	1p	2p	3p	4p	5p	6p	7p	8p	9p	10p	11p

Bolus:

	Breakfast	Snack	Lunch	Snack	Dinner	Snack	Bedtime	Overnight (what do you do at night?)
Target								
Meal bolus								
Correction bolus								