CURRENT INSULIN PLAN

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

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

Does your child wear a continuous glucose monitor (CGM)? □ Yes □ No **If yes, which device?**_____

Basal/Bolus Insulin Plan

Long-Acting Insulin Name:	Time: Amount:	Time: Amount:	
Intermediate-Acting Insulin Name:	Time: Amount:	Time: Amount:	

Rapid-Acting Insulin Name:

	Breakfast	Snack	Lunch	Snack	Dinner	Snack	Bedtime
Carbohydrate Ratio							
Correction Factor							
Target							

Sliding Scale Insulin Plan (May attach a copy of what you use at home):

Blood glucose	Breakfast	Lunch	Dinner

Long-Acting Insulin name, amount, and time:

Intermediate-Acting Insulin name, amount, and time:

Rapid-Acting Insulin name:

CURRENT INSULIN PLAN

INSULIN PUMP

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

Camper can change own infusion set: Yes □ No □ Partial □ Camper can fill pump reservoir: Yes □ No □

Does your child wear a continuous glucose monitor (CGM)? □ Yes □ No If yes, which device?_____

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?)
Carbohydrate Ratio								
Correction Factor								
Target								