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):

Glucose	Breakfast	Lunch	Dinner	Bedtime

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	**12a**	**1a**	**2a**	**3a**	**4a**	**5a**	**6a**	**7a**	**8a**	**9a**	**10a**	**11a**	**12p**	**1p**	**2p**	**3p**	**4p**	**5p**	**6p**	**7p**	**8p**	**9p**	**10p**	**11p**
Basal rates:																								

								Breakfast		Snack		Lunch		Snack		Dinner		Snack		Bedtime			
Bolus	**12a**	**1a**	**2a**	**3a**	**4a**	**5a**	**6a**	**7a**	**8a**	**9a**	**10a**	**11a**	**12p**	**1p**	**2p**	**3p**	**4p**	**5p**	**6p**	**7p**	**8p**	**9p**	**10p**	**11p**
Carbohydrate Ratio																								
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