CURRENT INSULIN PLAN – DAY CAMP

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

<table>
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<tr>
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<th>Long-Acting Insulin</th>
<th>Intermediate-Acting Insulin</th>
<th>Rapid-Acting Insulin</th>
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<tbody>
<tr>
<td>Name:</td>
<td>Time:</td>
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<td>Amount:</td>
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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):

Parent/Guardian Signature: __________________________
Date: ________________

State-authorized Medical Provider Signature: __________________________
Date: ________________

Long-Acting Insulin name, amount, and time: ______________________
Intermediate-Acting Insulin name, amount, and time: ________________
Rapid-Acting Insulin name: __________________________
CURRENT INSULIN PLAN – DAY CAMP

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: ______________

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<th>2a</th>
<th>3a</th>
<th>4a</th>
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Parent/Guardian Signature: ______________________________

Date: ______________

State-authorized Medical Provider Signature: ______________________________

Date: ______________