

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

<p>Long-Acting Insulin name, amount, and time:</p> <p>Intermediate-Acting Insulin name, amount, and time:</p> <p>Rapid-Acting Insulin name:</p>
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CURRENT INSULIN PLAN

INSULIN PUMP

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

Camper can change own infusion set: Yes No Partial Camper can draw up cartridge of insulin: Yes No

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

Have you already changed the home dose to a lower dose for camp? 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?)
Carbohydrate Ratio								
Correction Factor								
Target								

Parent/Guardian Signature _____ Date _____ State-authorized Medical Provider Signature _____ Date _____ On-site nurse signature _____ Date _____
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