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?**____________________________

Does your child use a non-FDA approved device, or is your child participating in an associated clinical trial? If yes, please provide details so we can care for your child appropriately:

____

Does your child perform sensor changes independently? Yes □ No □

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):

Long-Acting Insulin name, amount, and time:

Intermediate-Acting Insulin name, amount, and time:

Rapid-Acting Insulin name:

Parent/Guardian Signature:__________________________________

Date:__________________

State-authorized Medical Provider Signature:______________________________

Date:__________________

CURRENT INSULIN PLAN – DAY CAMP

INSULIN PUMP

NAME: ______________________________________ AGE: ______ PUMP START DATE: ________________

PUMP/INFUSION SET 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?________________________________**

Camper can change own sensor: Yes ☐ No ☐ **Date of last site change: _________** **Date of last sensor change: ______________**

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																								
Correction Factor																								
Target																								

Parent/Guardian Signature:________________________________

Date:__________________

State-authorized Medical Provider Signature:________________________________

Date:__________________