

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? _____

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 change their own sensor independently? Yes No Date of last sensor change: _____

Rapid Acting Insulin Type: _____

Bolus	Breakfast		Snack		Lunch		Snack		Dinner		Snack		Bedtime												
	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																									

Basal/Bolus Insulin Plan - Injections

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

INSULIN PUMP

PUMP START DATE: _____

PUMP/INFUSION SET TYPE: _____ Camper can change own infusion set: Yes No Partial

Camper can fill pump reservoir: Yes No Date of last site 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:																									

Sliding Scale Insulin Plan (Attach a copy of what you use at home)