

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):

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: _____