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: _____

								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																								

Basal/Bolus Insulin Plan - Injections

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