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:_____