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:

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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)