

INSULIN BY INJECTION

NAME: _____ **AGE:** _____ **WEIGHT** _____ **DATE:** _____ **PROGRAM:** _____

Does your child perform blood glucose monitoring independently? Yes No

Does your child give his/her own injections? Yes No

Long-Acting Insulin Name:	Time:	Time:					
	Amount:	Amount:					
Short-Acting Insulin Name:	Time:	Time:					
	Amount:	Amount:					
Intermediate-Acting Insulin Name:							
	Breakfast	Snack	Lunch	Snack	Dinner	Snack	Bedtime
Blood Glucose Target							
Correction Bolus							
Meal Bolus							

Or sliding scale below (May attach a copy of what you use at home):

Blood glucose	Breakfast	Lunch	Dinner

Parent/Guardian Signature _____
Date _____

Physician's Signature _____
Date _____

On site nurse signature _____
Date _____

INSULIN PUMP

NAME : _____ **AGE:** _____ **WEIGHT:** _____ **PUMP START DATE:** _____
PUMP TYPE: _____ **INSULIN:** _____

Camper can change own infusion set: YES NO Partial **Camper can draw up cartridge of insulin:** YES NO uses pre-filled

Have you changed the home dose to the camp dose? YES NO

Date of last site change: _____ **Infusion set used:** _____

Basal rates:

12	1a	2a	3a	4a	5a	6a	7a	8a	9a	10a	11a	12	1p	2p	3p	4p	5p	6p	7p	8p	9p	10p	11p	

Bolus:

	Breakfast	Snack	Lunch	Snack	Dinner	Snack	Bedtime	Overnight (what do you do at night?)
Target								
Meal bolus								
Correction bolus								

Parent/Guardian Signature _____
Date _____

Physician's Signature _____
Date _____

On site nurse signature _____
Date _____