Camper Name: _____ Birthdate: _____

TYPE 1 DIABETES MEDICAL FORM

TO BE COMPLETED BY PARENT/GUARDIAN

Child's Name:_____DOB: _____

Parent's Name:_____Phone: _____

Child's Diabetes Specialist:_____Phone: _____

Attach the most recent insulin orders/regimen from your child's diabetes provider

(Remember to send all insulins, insulin pump, CGM, glucagon, testing supplies and glucose)

Does your child have an insulin pump? Yes No If yes, brand: _____

How often is the site changed?_____Can your child do this independently? _____

Date Last Changed:_____

If not, what support is needed? _____

What is the insulin to carb ratio for the following?

Breakfast _____ AM Snack _____ Lunch_____

Afternoon snack_____Supper_____ Bedtime snack _____

Does your child have a continuous glucose monitor? Yes No If yes, brand: _____

Date Changed:_____Next Change Due:_____Independent with Change? Yes No

---

If your child does not have an insulin pump, what is your child's insulin regimen? Short

Acting Insulin: _____

For Meals/ Snacks:

Use 1unit of_____for each_____grams of carbohydrates before meals Add 1

Unit of_____for each_____mg/dl in BG above 150 mg/dl up to_____units

Add 1 Unit of_____for each_____mg/dl in BG above_____mg/dl up to units

Add 1 Unit of_____for each mg/dl in BG above_____mg/dl up to_____units

Long Acting Insulin:_____Dose_____Time of day administered_____

Other Insulin:_____Dose_____Time of day administered_____

Glucagon prescribed for low blood sugar? Yes No Dose_____Date last administered_____

Typical signs of low blood sugar in your child: _____

Preferred source of glucose if the blood sugar level is low? Yes No If yes, describe _____

Insulin modified for activity level? Yes No If yes, describe _____

Hospitalized for DKA? ◯Yes ◯No Details:_____