



SHOTS OR NON-PUMP RECENT DIABETES INFORMATION

Camper's Name _____ (for camp use only Cabin # _____)

Please label all diabetes supplies, especially meter, lancing device, and CGM receiver.

1. **Recent physical activity level**—How many hours per day does your child spend in:

___ Low activity such as sleeping, watching TV, or playing video games

___ Moderate activity such as walking, playing outside with friends, or shopping

___ High activity such as basketball, swimming, bicycling, or running

2. **Yes or No:** Has your child been hospitalized with Diabetic Ketoacidosis (DKA) in the last 6 months?

If so, when, and what were the circumstances? _____

3. Type of **long acting insulin:** _____ **Pens or syringes:** _____

Type of **short acting insulin:** _____

Type of **premixed insulin:** _____

4. Usual **Insulin dosing:**

Long Acting: Time: _____ Dose: _____

Short Acting:

Time	Carb Ration	Correction Scale - Sliding Scale	Target BG
Breakfast			
Lunch			
Dinner			
Snack			
Bedtime			

Premixed: Time: _____ Dose: _____

Where does the camper inject insulin? _____

5. Last 24 hours of **BG and doses of insulin: (Be sure time and date are correct in meter)**

Date	Time	BG/CGM	Carbs	Dose of Insulin

6. Anything else you want to share for your camper to have the best week at camp?



PUMP USER RECENT DIABETES INFORMATION

Camper's Name _____ (for camp use only Cabin # _____)

Please label all diabetes supplies, especially meter, lancing device, and CGM receiver

1. Recent physical activity level

How many hours per day does your child spend in:

____ Low activity such as sleeping, watching TV, or playing video games

____ Moderate activity such as walking, playing outside with friends, or shopping

____ High activity such as basketball, swimming, bicycling, or running

2. Yes or No: Has your child been hospitalized with Diabetic Ketoacidosis (DKA) in the last 6 months?

If so, when, and what were the circumstances? _____

3. Type of pump: _____ **Type of insulin:** _____

Type of infusion set: _____ **Last infusion set change:** _____

If using a sensor, **type of sensor:** _____ **When was sensor last inserted?** _____

Time	Basal	Time	Carb Ratio	Time	Correction	Target BG

5. Last 24 hours of BG and doses of insulin: (Be sure time and date are correct in pump)

Date	Time	BG/CGM	Carbs	Bolus

6. Yes or No: Does the pump have any damage such as a recent hard drop, visible cracks, torn buttons, blurry numbers on the screen, or a broken battery/cartridge cap?

7. Anything else you want to share for your camper to have the best week at camp?