The League ~ Camping & Recreation
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THIS FORM IS REQUIRED FOR PARTICIPANTS WHO ARE INSULIN DEPENDENT OR REQUIRE BLOOD GLUCOSE MONITORING AT CAMP

DIABETES FORM

This form MUST be signed & dated by a physician

Participant Name:_____ DOB: _____

Disability:_____ Allergies: _____

Type of Diabetes:

Restrictions to camp programming due to diabetic concerns:

Does this participant require blood glucose monitoring?_____Yes;_____No. If yes, please complete the following:
Target Range for blood glucose monitoring at camp: _____
Blood glucose monitoring should occur at the following times:

- ☐ Before meals
- ☐ Before snacks
- ☐ With signs/symptoms of hypo/hyperglycemia
- ☐ With signs/symptoms of illness
- ☐ Other:
- ☐ _____hours after meals
- ☐ _____hours after a correction dose

Hypoglecemia- blood glucose less than _____

- ☐ Self treatment for mild lows
- ☐ Give_____grams of fast-acting carbohydrate according to care plan.
  Recheck blood glucose level in 10-15 minutes. Repeat treatment if blood glucose level is less than_____mg/dl
- ☐ Provide extra protein and carbohydrate snack after treating low if next meal/snack is greater than_____minutes away
- ☐ Suspend pump for severe hypoglycemia for_____minutes

If camper is unconscious, having a seizure, or is unable to swallow, presume they have low blood sugar. Call 911, notify guardian, and:

- ☐ Glucagon injection (1mg/1cc)_____mg, subcutaneously or intramuscular
- ☐ OK to use glucose gel inside cheek, even if unconscious or seizing
- ☐ Other:

Hyperglecemia- blood glucose greater than _____

- ☐ Check urine ketones, follow care plan, administer insulin as per orders
- ☐ Encourage sugar free fluids, at least_____ounces per _____
- ☐ If camper complains of nausea, vomiting, or abdominal pain, check urine ketones and insulin administration orders
- ☐ Other:

Meal Plan

☐ Breakfast time:_____ ☐ Lunch time: _____ ☐ Dinner time: _____

☐ Snack times: _____ ☐ Avoid snack if blood glucose greater than_____mg/dl

Please list any specific diet requirements and/or restrictions:

Transportation

☐ Blood glucose monitoring is not required prior to boarding a vehicle

☐ Check blood glucose 15 minutes prior to boarding vehicle

☐ Allow participant to eat on vehicle if having symptoms of low blood glucose

☐ Other:

Does this participant require insulin?_____Yes;_____No. If yes, please complete the following:

Name of Insulin: _____

Insulin is administered via: ☐ yringe/vial ☐ nsulin Pen ☐ nsulin Pump ☐ Other: _____

Insulin is given before meals at the following doses:

☐ Routine Dose: _____

☐ Per sliding scale as follows:

Blood Glucose_____to _____, give_____units

Blood Glucose_____to _____, give_____units

Blood Glucose_____to _____, give_____units

Blood Glucose_____to _____, give_____units

☐ Calculated Insulin dose (add carbohydrate coverage and correction dose for total insulin dose):

Carbohydrate coverage: Insulin to carbohydrate ratio

Give_____unit(s) of insulin per_____grams carbohydrate

Correction:

Give_____unit(s) of insulin per_____mg/dl of glucose **above**_____mg/dl

Subtract_____unit(s) for every_____mg/dl of glucose **below**_____mg/dl

☐ Insulin may be given after meals if: _____

☐ Other times insulin may be given:

☐ Snack ☐ Dose:_____ ☐ Calculated as above

☐ Ketones If ketones are_____, give/add_____unit(s)

Health Care Provider Assessment

Participant can self-perform the following procedures (Health Center staff and guardian must verify competency):

☐ Blood glucose monitoring ☐ Determine insulin dose ☐ Measure insulin

☐ Inject insulin ☐ Operate insulin pump independently

☐ Other:

Physician Signature:_____ **Date:** _____

Printed Name:_____ **Phone:** _____

Legal Guardian Signature:_____ **Date:** _____