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:_____

Upload to parent dashboard, fax form to 888-524-2477 or email to camperrecruiter@roundupriverranch.org.