Camper Name:_____ Birthdate: _____

INFUSION PUMP FORM

TO BE COMPLETED BY A LICENCED HEALTH CARE PROVIDER

Complete this form only if the child uses an infusion pump, IV fluids or TPN pump, gastrostomy feeding pump, etc. OR you may fax a signed Home Care Order in place of this form.

All necessary supplies for camp must be sent with the child including medication, sterile water, needles, syringes, backup batteries, formula, and extra GT/NG tubes.

Home care agency and contact numbers _____

Manufacturer and model of pump _____

Procedure to replace broken pump_____

_____

Instructions for infusion pumps

Med dose _____

Concentration and amount of saline flush _____

Length and rate of infusion _____

Number of nights pump is to be used at camp _____

Instructions for infusion or feeding

Continuous feeds: GT NG J-tube Other_____

Product and Quantity _____

Starting rate_____ml/min X_____hrs (taper up)

Maint rate_____ml/min X_____hrs

Ending rate_____ml/min X_____hrs (taper down)

Bolus feeds

Product and Quantity _____

When is it given? _____

How is it given? (pump, gravity, push) _____

Is extra water given? No Yes *If yes, how much and when?* _____

Special Instructions

_____

_____

_____ _____ _____

Physician Name (Print) **Signature** **Date**

_____ _____ _____

Completed by (Print Name) **Signature** **Date**

Upload to parent dashboard or fax form to 888-524-2477