girl scouts
nation's capital

Camper's Name: _____
Date of Birth: _____/_____/_____ Age: _____
Address: _____
Name of Camp: _____
Program: _____ Session: _____
☐ Camper is attending more than one Sleep Away Camp program this summer.

Sleep Away Camp 2021

Specialized Health Care

Diabetes Medical Management Plan

Must be completed if your camper has diabetes. <u>Parent/guardian and physician signature required.</u>
We will also accept copies of current, physician approved plans from camper's camp/daycare

This plan was adapted from the Virginia Public School Diabetes Management Plan 2018/19 for use at sleep-away camp. This plan should be completed by the camper's personal diabetes health care team, including the parents/guardians. It should be reviewed with relevant camp staff and copies should be kept in a place that can be accessed easily by the camp health staff, trained diabetes personnel, and other authorized personnel.

General information

Camper's name: _____ Date of birth: _____
Date of diagnosis: _____☐ Type 1 ☐ Type 2 ☐ Other: _____

Parent/guardian 1: _____
Address: _____
Telephone: Home: _____ Work: _____Cell: _____
Email address: _____

Camper's physician / health care provider: _____
Address: _____
Telephone: _____ Emergency Number: _____
Email Address: _____

Checking blood glucose

Target range of blood glucose: ❑ Before Meal _____ - _____ mg / dL ❑Other _____

Check blood glucose level:

❑ _____ Hours/mins after waking ❑ Before meals ❑ _____ Hours after meals
❑ _____ Hours after correction dose ❑ Before physical activity ❑ After Physical Activity
❑ _____ hours/mins before bed ❑ As needed for signs/symptoms of illness
❑ As needed for signs/symptoms of high/low blood glucose
❑ Other: _____

Camper's self-care blood glucose checking skills:

☐ Independently checks own blood glucose
☐ May check blood glucose with supervision
☐ Requires a camp health staff member or trained diabetes personnel to check blood glucose
☐ Uses a smartphone or other monitoring technology to track blood glucose values

Continuous Glucose Monitoring (CGM) ❑ Yes ❑ No Brand/model: _____

Alarms set for: ❑ Severe Low: _____ ❑ Low: _____ ❑ High: _____

Predictive alarm: ❑ Low: _____ ❑ High: _____ Rate of change: ❑ Low: _____ ❑ High: _____

Threshold suspend setting: _____

Additional information for camper with CGM

- Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level.
- If the camper has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM.
- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports activities.
- If the adhesive is peeling, reinforce it with any medical adhesive or tape the parent / guardian has provided.
- If the CGM becomes dislodged, remove, and return everything to the parents/guardian. Do not throw anything away.
- Refer to the manufacturer's instructions on how to use the camper's device.

Camper's Self-care CGM Skills	Independent?	
The camper is able to troubleshoot alarms and malfunctions.	❑ Yes	❑ No
The camper is able to respond to HIGH alarm.	❑ Yes	❑ No
The camper is able to respond to LOW alarm.	❑ Yes	❑ No
The camper is able to adjust alarms.	❑ Yes	❑ No
The camper is able to calibrate the CGM.	❑ Yes	❑ No
The camper is able to respond when the CGM indicates a rapid trending rise or fall in the blood glucose level.	❑ Yes	❑ No
The camper should be escorted to the nurse if the CGM alarms	❑ High	❑ Low
Other instructions for the camp health team:		

Hypoglycemia (Low Blood Glucose)

Hypoglycemia: Any blood glucose below **_____ mg / dL** checked by blood glucose meter.

Has your child ever experienced an episode of hypoglycemia that required an emergency response? ☐ No ☐ Yes Date: _____ Details:

Camper's frequency of hypoglycemia

☐ Once a day ☐ Once a week ❑ Once a month ❑ Other: _____

When was their last episode? _____

What time of day is most common for hypoglycemia to occur? _____

_____ _____

Health Care Provider Signature Date

Camper's usual symptoms of hypoglycemia include (circled):

Hunger	Sweating	Shakiness	Paleness	Dizziness
Confusion	Loss of coordination	Fatigue	Irritable	Crying
Headache	Inability to concentrate	Anger	Passing-out	Seizure

Mild to Moderate Hypoglycemia:

- Camper is exhibiting symptoms of hypoglycemia above. AND
- Blood glucose is < _____ mg / dL
- Camper is conscious and able to swallow.

1. Immediately give 15 grams fast-acting carbohydrate (example - 3-4 glucose tablets; 4 ounces of regular soda/juice, gummies, starburst, or one small tube glucose/cake gel)

2. Recheck blood glucose in 15 minutes

3. If blood glucose level is < _____ mg/dL, repeat treatment with 15 grams of fast-acting carbohydrates and repeat blood glucose in 15 minutes.

4. Once blood glucose is > _____ mg/dL

- If at a meal, let camper eat and cover carbohydrate per orders.
- If not at a meal, provide camper slow-release carbohydrate snack (example: 3-4 cheese crackers or ½ sandwich)
- Resume normal activities.

5. **If unable to raise blood glucose above _____ mg/dL after providing 3 treatments with fast acting glucose.**

- Call parent/guardian.
- Notify Camp Health Director (APRN) and Camper's Health Care provider.
- If unable to reach any of the above, call 911.

Severe Hypoglycemia:
Camper is unconscious or unresponsive, unable to eat or drink, unable to control their airway, and/or is seizing/convulsing.

1. Position the camper on his or her side to prevent choking

2. Reconstitute glucagon per medication instructions:

- **Administer Glucagon**
  Dose: ☐ 1 mg ☐ 0.5 mg ❑ Other_____
  Route: ☐ Subcutaneous (SC) ☐ Intramuscular (IM)
  Site: ☐ Buttocks ☐ Arm ☐ Thigh ☐ Other: _____

3. Call 911 for emergency assistance

- AND the camper's parents / guardians.
- AND Camp Health Director (APRN)

4. If on INSULIN PUMP, Stop insulin pump by any of the following methods:

- Place pump in "suspend" or "stop mode" (See manufacturer's instructions)
- Disconnect at site
- Cut tubing

ALWAYS send pump with EMS to hospital

_____ _____
Health Care Provider Signature Date

Hyperglycemia (High Blood Glucose) If suspected, check blood glucose level with a finger check.

Hyperglycemia: Any blood glucose above _____ mg/dL. .

Camper's usual symptoms of hyperglycemia include (circled):

Extreme thirst	Frequent urination	Blurry Vision	Hunger	Headache
Nausea	Hyperactivity	Irritable	Dizziness	Stomach ache

If hyperglycemia is suspected

1. **Check the blood glucose level with finger check.**
2. **Encourage camper to drink fluids, 8oz water when hyperglycemia is present.**

If blood glucose is >_____ mg/dL - two times in a row, at least one hour apart, and/or when camper complains of nausea, vomiting, or abdominal pain, then

1. **Check ketones**
2. **If unable to check ketones:**
   - Give 8 oz of water and retest blood glucose in 1 hour
   - If camper complains of nausea, vomiting, or abdominal pain, call parent and Camp Health Director (APRN).
   - If camper exhibits any emergency symptoms, **call 911** (see below)

Insulin Correction Dose

For blood glucose greater than _____mg/dL AND at least _____ hours since last insulin dose, give correction dose of insulin (see correction dose orders, page 5).

Notify parents/guardians if blood glucose is over _____ mg/dL.
For insulin pump users: see "Additional Information for Camper with Insulin Pump", page 6".

HYPERGLYCEMIA EMERGENCY

HYPERGLYCEMIA EMERGENCY if individual has large ketones and the below symptoms

Call 911

Chest pain	Nausea and vomiting	Severe abdominal pain
Heavy breathing or shortness of breath	Increasing sleepiness or lethargy	Depressed level of consciousness

Call parent/guardian AND **Camp Health Director (APRN)**

IF ON INSULIN PUMP: Follow the above instructions, plus give insulin correction by insulin vial and syringe and/or insulin pen, not by insulin pump bolus.

ALWAYS send pump with EMS to hospital

_____ _____

Health Care Provider Signature Date

Insulin therapy

Insulin delivery device: ❑ Insulin pen ❑ Insulin syringe ❑ Insulin pump (refer below)

Type of Insulin therapy at camp: ❑Adjustable(basal-bolus) insulin ❑Fixed insulin therapy ❑ None

Adjustable (Basal-Bolus) Insulin Therapy
Insulin Type: Apidra ; Novolog; or Humalog

Carbohydrate Coverage/ Insulin-to-carbohydrate ratio:

- ❑ *Breakfast:* ____ unit of insulin per_____ gm of carbohydrate
- ❑ *Lunch:* _____ unit of insulin per_____ gm of carbohydrate
- ❑ *Snack:* _____ unit of insulin per_____ gm of carbohydrate
- ❑ *Dinner:* _____ unit of insulin per_____ gm of carbohydrate

Carbohydrate Dose Calculation Example
Total Grams of Carbohydrate to Be Eaten / _____ = *Units of Insulin* / *Insulin-to-Carbohydrate Ratio*

❑ **Correction Dose:**
May be used to administer insulin for elevated blood glucose if greater than _____hours since last insulin dose:
Blood glucose correction factor (insulin sensitivity factor) = _____
Target blood glucose = _____mg/dL

Correction Dose Calculation Example
Current Blood Glucose – Target Blood Glucose / _____ = *Units of Insulin* / *Correction Factor*

❑ **Correction dose scale** (use instead of calculation above to determine insulin correction dose):
May be used to administer insulin for elevated blood glucose if greater than _____ hours since last insulin dose

Blood glucose _____ to _____ mg/dL, give _____ units
Blood glucose _____ to _____ mg/dL, give _____ units
Blood glucose _____ to _____ mg/dL, give ____ units
Blood glucose _____ to _____ mg/dL, give ____ units

When to give insulin:

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.

☐ Other: _____

Meals:

☐ Carbohydrate coverage only

☐ Carbohydrate coverage plus correction dose when blood glucose is greater than _____ mg/dL and _____ hours since last insulin dose.

☐ Other: _____

_____ _____
Health Care Provider Signature Date

Insulin therapy (continued)

Fixed Insulin Therapy Name of insulin: _____

☐ _____ Units of insulin given pre-breakfast daily ☐ _____ Units of insulin given pre-lunch daily

☐ _____ Units of insulin given pre-snack daily ☐ Other: _____

Parents/Guardians Authorization to Adjust Insulin Dose		
Parents/guardians authorization should be obtained before administering a correction dose.	☐ Yes	☐ No
Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.	☐ Yes	☐ No
Parents/guardians are authorized to increase or decrease insulin-to carbohydrate ratio from: ____ unit(s) for every _____grams of carbohydrate **to** ____ unit(s) for every _____grams of carbohydrate	☐ Yes	☐ No
Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.	☐ Yes	☐ No

Camper's Self-Care Insulin Administration Skills
☐ Independently calculates / gives own injections.
☐ May calculate / give own injections with supervision.
☐ Requires Health Staff nurse or trained diabetes personnel to calculate dose and camper can give own injection with supervision.
☐ Requires Health Staff nurse or trained diabetes personnel to calculate dose and give the injection.

Additional Information for Campers with Insulin Pumps

Brand / model of pump: _____ Insulin Type: Apidra ; Novolog; or Humalog

Basal rates during camp: Time: _____ Basal rate: _____ Time: _____ Basal rate: _____

Time: _____ Basal rate: _____ Time: _____ Basal rate: _____

Other pump instructions: _____Type of infusion set / infusion site(s) :_____

☐ If Blood glucose greater than _____mg/dL that has not decreased within _____hours after correction and / or if camper has moderate to large ketones. Notify parents/ guardians

☐ For infusion site failure: Insert new infusion set and/or replace reservoir, or give insulin by syringe or pen.

☐ For suspected pump failure: Suspend or remove pump and give insulin by syringe or pen.

Adjustments for Physical Activity Using Insulin Pump

May disconnect from pump for sports activities: ☐ Yes, for _____ hours	☐ No	☐ Per parent
Set temporary basal rate: ☐ Yes, ____% temporary basal for ___ hours	☐ No	☐ Per parent
Suspend pump use: ☐ Yes, for _____ hours	☐ No	☐ Per parent

_____ _____

Health Care Provider Signature Date

Insulin therapy (continued)

Camper's Self-care Pump Skills	Independent?	
Counts carbohydrates	☐ Yes	☐ No
Calculates correct amount of insulin for carbohydrates consumed	☐ Yes	☐ No
Administers correction bolus	☐ Yes	☐ No
Calculates and sets basal profiles	☐ Yes	☐ No
Calculates and sets temporary basal rate	☐ Yes	☐ No
Changes batteries	☐ Yes	☐ No
Disconnects pump	☐ Yes	☐ No
Reconnects pump to infusion set	☐ Yes	☐ No
Prepares reservoir, pod, and/or tubing	☐ Yes	☐ No
Inserts infusion set	☐ Yes	☐ No
Troubleshoots alarms and malfunctions	☐ Yes	☐ No

Other diabetes medications

Name: _____ Dose: _____ Route: _____ Times given: _____

Name: _____ Dose: _____ Route: _____ Times given: _____

Name: _____ Dose: _____ Route: _____ Times given: _____

Meal Plan and Nutritional Needs

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast		_____ to _____
Mid-morning snack		_____ to _____
Lunch		_____ to _____
Mid-afternoon snack		_____ to _____
Other times to give snacks and content/amount:		
Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):		

Special dietary concerns/ allergies/ medications:

Camper's self-care nutrition skills:

☐ Independently counts carbohydrates
☐ May count carbohydrates with supervision
☐ Requires camp nurse/trained diabetes personnel to count carbohydrates

_____ _____

Health Care Provider Signature Date

Physical activity and sports - A quick-acting source of glucose must be available at the site of physical education activities and sports. Examples include glucose tabs, sugar-containing juice. Camper should eat:

Carbohydrate Amount	Before	Every 30 minutes	Every 60 minutes	After activity	Per Parent
15 grams	☐	☐	☐	☐	☐
30 grams	☐	☐	☐	☐	☐

If most recent blood glucose is less than _____mg/dL, camper can participate in physical activity when blood glucose is corrected and above _____mg/dL.

Avoid physical activity when blood glucose is greater than _____mg/dL or if urine ketones are moderate to large / blood ketones are > 1.0 mmol/L.

Authorization to Treat and Administer Medication in the Camp Setting

This Diabetes Medical Management Plan has been approved by the undersigned Health Care Provider. It further authorizes the Camp Health Staff to treat and administer medication as indicated by this plan and according to state laws and regulations.

Medication Authorization: Necessary for ALL prescription and Non-prescription medications administered at camp. *Please use Brining Medication Form A or B for additional medications needed.*

Medication Name: ☐ Prescription ☐ Non	Dosage/Strength:	Type of Device:	
Time Given: (For what symptoms)	Time Interval/ Repeating Dose::	Relevant side effects: (Specify)	☐ none expected
Medication Name: ☐ Prescription ☐ Non	Dosage/Strength:	Type of Device:	
Time Given: (For what symptoms)	Time Interval/ Repeating Dose:	Relevant side effects: (Specify)	☐ none expected
Medication Name: ☐ Prescription ☐ Non	Dosage/Strength:	Type of Device:	
Time Given: (For what symptoms)	Time Interval/ Repeating Dose:	Relevant side effects: (Specify)	☐ none expected
Medication Name: ☐ Prescription ☐ Non	Dosage/Strength:	Type of Device:	
Time Given: (For what symptoms)	Time Interval/ Repeating Dose:	Relevant side effects: (Specify)	☐ none expected

Medication shall be administered during the year in which this form is dated below, unless more restrictive dates are specified here: From: _____/____/_____ To: _____/____/_____ (*This authorization is not to exceed 1 YEAR.*)

_____ _____

Health Care Provider Signature Date

Signatures:

Medical Providers:

My signature below provides authorization for the Diabetes Medical Management Plan contained herein and medications listed below. I understand that all treatments and procedures may be performed by the camper, the Camp Nurse, Camp Health Manager/Director, and/or unlicensed trained designated camp personnel, as allowed by camp policy, state laws, regulations and/or emergency services as outlined in this plan. I have indicated below if I give permission to the camper to carry with and use supplies, including a reasonable and appropriate short-term supply of carbohydrates, an insulin pump, and equipment for immediate treatment of high and low blood glucose levels, and to self-check their own blood glucose levels while at sleep away camp.

PRESCRIBER'S SIGNATURE	DATE	SELF-ADMINISTER INSULIN ☐ Yes ☐ No
PRESCRIBER'S NAME AND TITLE		SELF-MONITOR GLUCOSE ☐ Yes ☐ No If yes, ☐ with ☐ without supervision
PRESCRIBER'S ADDRESS		PRESCRIBER'S PHONE
SPACE FOR PRESCRIBER'S STAMP		

Parents:

I also consent to the release of information contained in this Diabetes Medical Management Plan to all camp staff members and other adults who have responsibility for my camper and who may need to know this information to maintain my camper's health and safety. I also give permission to the camper health staff or another qualified health care professional to contact my camper's diabetes health care providers. Moreover, I have indicated below if I give permission to the camper to carry with and use supplies, including a reasonable and appropriate short-term supply of carbohydrates, an insulin pump, and equipment for immediate treatment of high and low blood glucose levels, and to self-check their own blood glucose levels while at sleep away camp.

PARENT/GUARDIAN SIGNATURE	DATE	SELF-ADMINISTER INSULIN ☐ Yes ☐ No
PRINTED NAME		SELF-MONITOR GLUCOSE ☐ Yes ☐ No If yes, ☐ with ☐ without supervision

Suggested Supplies to Bring to Camp

• Glucose meter, testing strips, lancets, and batteries for the meter • Insulin(s), syringes, and/or insulin pen(s) and supplies • Glucagon emergency kit	• Insulin pump and supplies in case of failure: Reservoirs, sets, prep wipes, pump batteries / charging • Treatment for low blood sugar • Protein containing snacks: such as granola bars • Other medication

Camp Health Staff

By signing below, I acknowledge that I have reviewed the Diabetes Medical Management Plan contained herein and will consult the camper's parents/guardians and/or the camper's health care provider as need during the camper's stay at sleep-away camp.

I have indicated below if I give permission for the camper to carry with and use supplies, including a reasonable and appropriate short-term supply of carbohydrates, an insulin pump, and equipment for immediate treatment of high and low blood glucose levels, and to self-check their own blood glucose levels while at sleep away camp.

CAMP HEALTH STAFF SIGNATURE	DATE	SELF-ADMINISTER INSULIN ☐ Yes ☐ No If yes, ☐ with ☐ without supervision
PRINTED NAME		SELF-MONITOR GLUCOSE ☐ Yes ☐ No If yes, ☐ with ☐ without supervision
NOTES:		