

Camper's Name: _____
 Date of Birth: ____/____/____ Age: _____

 Address: _____

 Name of Camp: _____

Day & Evening Camp 2022

Specialized Health Care Form

Diabetes Medical Management Plan

Must be completed if your camper has diabetes. Parent/guardian and physician signature required.

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 day and evening 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The camper is able to respond to HIGH alarm.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The camper is able to respond to LOW alarm.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The camper is able to adjust alarms.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The camper is able to calibrate the CGM.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The camper is able to respond when the CGM indicates a rapid trending rise or fall in the blood glucose level.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The camper should be escorted to the nurse if the CGM alarms	<input type="checkbox"/> High	<input type="checkbox"/> 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** Dose: 1 mg 0.5 mg Other _____
 - Glucagon** 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

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

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: _____

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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Parents/guardians are authorized to increase or decrease correction dose scale within the following range: +/- _____ units of insulin.	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: +/- _____ units of insulin.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Camper's Self-Care Insulin Administration Skills
<input type="checkbox"/> Independently calculates / gives own injections. <input type="checkbox"/> May calculate / give own injections with supervision. <input type="checkbox"/> Requires Health Staff nurse or trained diabetes personnel to calculate dose and camper can give own injection with supervision. <input type="checkbox"/> 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: <input type="checkbox"/> Yes, for _____ hours	<input type="checkbox"/> No	<input type="checkbox"/> Per parent
Set temporary basal rate: <input type="checkbox"/> Yes, _____% temporary basal for _____ hours	<input type="checkbox"/> No	<input type="checkbox"/> Per parent
Suspend pump use: <input type="checkbox"/> Yes, for _____ hours	<input type="checkbox"/> No	<input type="checkbox"/> Per parent

Health Care Provider Signature _____

Date _____

Insulin therapy (continued)

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

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30 grams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:	<input type="checkbox"/> Prescription	<input type="checkbox"/> Non	Dosage/Strength:	Type of Device:
Time Given: (For what symptoms)	Time Interval/ Repeating Dose::		Relevant side effects: (Specify) <input type="checkbox"/> none expected	
Medication Name:	<input type="checkbox"/> Prescription	<input type="checkbox"/> Non	Dosage/Strength:	Type of Device:
Time Given: (For what symptoms)	Time Interval/ Repeating Dose:		Relevant side effects: (Specify) <input type="checkbox"/> none expected	
Medication Name:	<input type="checkbox"/> Prescription	<input type="checkbox"/> Non	Dosage/Strength:	Type of Device:
Time Given: (For what symptoms)	Time Interval/ Repeating Dose:		Relevant side effects: (Specify) <input type="checkbox"/> none expected	
Medication Name:	<input type="checkbox"/> Prescription	<input type="checkbox"/> Non	Dosage/Strength:	Type of Device:
Time Given: (For what symptoms)	Time Interval/ Repeating Dose:		Relevant side effects: (Specify) <input type="checkbox"/> 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 day/evening camp.

PRESCRIBER'S SIGNATURE	DATE	SELF-ADMINISTER INSULIN <input type="checkbox"/> Yes <input type="checkbox"/> No
PRESCRIBER'S NAME AND TITLE		SELF-MONITOR GLUCOSE <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> with <input type="checkbox"/> 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 day/evening camp.

PARENT/GUARDIAN SIGNATURE	DATE	SELF-ADMINISTER INSULIN <input type="checkbox"/> Yes <input type="checkbox"/> No
PRINTED NAME		SELF-MONITOR GLUCOSE <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> with <input type="checkbox"/> without supervision

Suggested Supplies to Bring to Camp

<ul style="list-style-type: none"> • Glucose meter, testing strips, lancets, and batteries for the meter • Insulin(s), syringes, and/or insulin pen(s) and supplies • Glucagon emergency kit 	<ul style="list-style-type: none"> • 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
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• 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 needed during the camper's time at day/evening 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 day/evening camp.

CAMP HEALTH STAFF SIGNATURE	DATE	SELF-ADMINISTER INSULIN <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> with <input type="checkbox"/> without supervision
PRINTED NAME		SELF-MONITOR GLUCOSE <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> with <input type="checkbox"/> without supervision
NOTES:		