Diabetes Management and Treatment Plan

Camper: _____ Birth date:_____

TO BE COMPLETED BY PHYSICIAN:
Please respond to the following questions based on your records and knowledge of the camper.

1. **Procedures:** (parent to provide supplies for procedures):
   Test blood glucose before lunch and as needed for signs/symptoms of hypoglycemia.
   Test urine ketones with blood glucose is hyperglycemic, and/or when child is ill.

2. **Medication:** (Child may _____ may not _____ prepare/administer insulin injection)
   Rapid Acting Insulin | Regular/Humalog/Novolog | given subcutaneously prior to lunchtime (within 30 minutes prior to lunch) based on the following guidelines:
   a. Fixed dose: _____units plus insulin correction scale; OR
   b. Insulin to Carbohydrate Ratio: 1 unit of insulin per _____ grams carbohydrate plus insulin correction scale

   Insulin Correction Scale
   Blood glucose below _____ = no additional insulin
   Blood glucose from _____ to _____ = _____unit(s) insulin subcutaneously
   Blood glucose from _____ to _____ = _____unit(s) insulin subcutaneously
   Blood glucose from _____ to _____ = _____unit(s) insulin subcutaneously
   Blood glucose over _____ = _____unit(s) insulin subcutaneously
   (Notify parent if blood glucose is over _____.)

   c. Oral Diabetes medication: _____ Dose_____ Time_____
   d. Camper is to eat lunch following pre-lunch blood test and required medication.
   e. Parents/family member instructed in diabetes self-management. Parent may_____ may not_____ adjust pre-lunch insuline dosage by up to 10% every 4 to 5 days as indicated by glucose trends. **Parent will communicate changes to camp health services personnel.**

Does this camper have an insulin pump? Yes____ No____. If yes, please attach camper's pump guidelines.

FOR DIABETIC SELF CARE ONLY
Does this camper have physician permission to provide self care? Yes_____ No_____
This camper has been provided instruction/supervision in recognizing signs/symptoms of hypoglycemia and is capable of doing self-glucose monitoring and his/her own insulin injections/insulin pump care, including using universal precautions and proper disposal of sharps? Yes_____ No_____
This camper requires the **supervision** of a designated adult _____
This camper requires the **assistance** of a designated adult _____

GUIDELINES FOR RESPONDING TO BLOOD GLUCOSE TEST RESULTS

1. **If glucose is BELOW _____:** (hypoglycemia or low blood sugar)
   - A. Give child 15 grams carbohydrate, i.e.:
     - 6 livesavers
     - 6 ounces of regular soda
     - 4 ounces of juice
     - 3 - 4 glucose tabs
   - B. Allow child to rest for 10-15 minutes, and retest glucose
   - C. If glucose is above _____, allow camper to proceed with scheduled meal, activity or snack.
   - D. If symptoms persist (or blood glucose remains below _____), repeat A and B.
   - E. If symptoms still persist, notify parents and keep child in clinic.

2. **If blood glucose is BELOW _____ and the child is unconscious or seizing:**
   - A. Call emergency medical services.
   - B. Rub a small amount of glucose gel (or cake frosting) on child's gums and oral mucosa.
   - C. If available, inject Glucagen _____mg. SQ.
   - D. Notify parent.

3. **If blood glucose is FROM _____ to _____: Follow usual meal plan and activities** (unless otherwise directed by insulin correction scale for insulin administration)

4. **If blood glucose is OVER _____:**
   - A. If within 30 minutes prior to lunch, nurses or unlicensed diabetes care assistant to be called if camper unable to administer correction dose of insulin per child's sliding scale orders.
   - B. Camper checks urine ketones.

     <u>If Ketones are negative or small</u>
     - Encourage water until ketones are negative.

     <u>If Ketones are moderate or large</u>
     - Camper should remain in clinic for monitoring,
     - Notify parent for pick up.
     - Give 1-2 glasses of water every hour.
     - If camper remains at camp, retest glucose and ketones every 2-3 hours or until ketones are negative.
   - C. Camper not to participate in forms of exercise if blood sugar is above 250 and ketones are present.
   - D. If camper develops nausea/vomiting, rapid breathing, and/or fruity odor to the breath, call 911, the nurse and the parents.

Physician signature_____ Date_____

Clinic/facility_____ Phone_____ Fax_____

TO BE COMPLETED BY THE PARENT:

We (I) the undersigned, the parents/guardians of _____ request that the above Diabetes Management and Treatment Plan be implemented for our (my) child. Delivery of this form to the camp nurse constitutes my participation in developing this Plan, and is my consent to implement this Plan. I will notify the camp immediately if the health status of my chile changes, if I change physicians or emergency contact information, or if the procedure is canceled or changes in any way. Information concerning my child's diabetes health management may be shared with/obtained from the diabetes health care providers.

Signature_____ Relationship_____

Date_____ Phone (cell)_____ (work) _____