



2024 DIABETES ORDER FORM - PAGE 1 of 2

If the participant has been diagnosed with diabetes and is under the age of 18, this form must be completed and signed by both the physician and the parent/legal guardian.

Participant's Full Name: _____ **D.O.B.:** _____

Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell: _____

Parent/Guardian: _____ Home Phone: _____ Work: _____ Cell: _____

Other Emergency Contact: _____

Insulin Orders (complete only if insulin is needed at camp):

1. Insulin administration via: Syringe and vial Insulin pen Other _____
 Insulin pump Type of pump: _____ Basal rates: _____
 Name of insulin: _____

2. Insulin Before lunch/snacks:

Routine lunchtime dose: _____

Per sliding scale as follows:

Meals

Blood Glucose _____ to _____ give _____ units
 Blood Glucose _____ to _____ give _____ units
 Blood Glucose _____ to _____ give _____ units
 Blood Glucose _____ to _____ give _____ units
 Blood Glucose _____ to _____ give _____ units
 Blood Glucose _____ to _____ give _____ units
 Blood Glucose _____ to _____ give _____ units
 Blood Glucose _____ to _____ give _____ units
 Blood Glucose _____ to _____ give _____ units
 Blood Glucose _____ to _____ give _____ units

Calculated insulin dose (add carbohydrate coverage and correction dose for total insulin dose):

Carbohydrate Coverage: Insulin to carbohydrate ratio

Give _____ # unit(s) insulin per _____ gms carbohydrates

Correction:

Give _____ # unit(s) insulin per _____ mg/dl of glucose above _____ mg/dl

Subtract _____ # unit(s) for every _____ mg/dl of glucose below _____ mg/dl

Insulin may be given after lunch if _____

3. Other times insulin may be given:

Snack: Dose: _____ Calculated as above

Snack:

Blood Glucose Give:

Ketones: If ketones are _____ Give/Add _____ unit(s) _____ units

If ketones are _____ Give/Add _____ unit(s) _____ units

Health Care Provider Authorization for Management of Diabetes at Beachmont Christian Camp

My signature below provides authorization for the above written orders. This authorization is for the summer of 2015. If changes are indicated, I will provide new written authorization, which may be faxed.

***Sign both pages**

Health Care Provider Name: _____ **Signature:** _____ (original or stamped signature)

Address: _____ **City:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Date:** _____

Parent Consent for Management of Diabetes at Beachmont Christian Day Camp

I request Beachmont Christian Day Camp personnel to administer the medication and treatment orders as prescribed above. I agree:

1. To provide the necessary supplies and equipment

2. To notify the camp nurse if there is a change in the student's diabetes management or health care provider.

I authorize Beachmont Christian Day Camp to communicate with the health care provider as necessary.

Parent/Guardian Signature: _____ **Date:** _____ ***Sign both pages**



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Participant's Full Name: _____ D.O.B. _____

Blood Glucose Monitoring:

Target range for blood glucose monitoring at camp: _____

- Before snacks 2 hours or _____ hours after lunch
- Before meals 2 hours or _____ hours after a correction dose
- As needed for symptoms of hypo/hyperglycemia
- With signs and symptoms of illness
- Other times: _____

Hypoglycemia – blood glucose less than _____

- Self treatment for mild lows.
- Give _____ grams of fast-acting carbohydrate according to care plan. Recheck BG in 10-15 minutes.
Repeat treatment if BG less than _____ mg/dl
- Provide extra protein & carbohydrate snack after treating low if next meal/snack greater than _____ minutes away.
- Suspend pump for severe hypoglycemia for _____ minutes.

**If participant is unconscious, having a seizure or unable to swallow, presume student is having a low blood sugar and:
Call 911, notify parent**

- Glucagon injection (1 mg in 1 cc) _____ mg, subcutaneously or intramuscular (IM)
- OK to use glucose gel inside cheek, even if unconscious, seizing.
- Other: _____

Hyperglycemia – blood glucose greater than _____

- Check urine ketone, follow care plan, administer insulin as per orders. For pumps, insulin may be given by syringe or pen if needed.
- Encourage sugar free fluids, at least _____ ounces per _____.
- If participant complains of nausea, vomiting or abdominal pain; check urine ketones & check insulin administration orders.
- Other: _____

*transport to local Emergency Room may be needed with vomiting and large ketones.

Meal Plan

- AM snack time: _____ PM snack time: _____ Avoid snack if blood glucose greater than _____ mg/dl.
- Lunch: _____
- Extra food allowed: Parent's discretion Participant's discretion

Exercise (check and/or complete all that apply)

Fast-acting carbohydrate source must be available before, during and after all exercise.

- With participant With Camp Staff
- If most recent blood glucose is less than _____, exercise can occur when blood glucose is corrected and above _____.
- Eat _____ grams of carbohydrate Before Every 30 mins during After vigorous exercise
- Avoid exercise when blood glucose is greater than _____ or ketones are _____

Health Care Provider Assessment

Participant can self-perform the following procedures (camp nurse and parent must verify competency):

- Blood glucose monitoring Measuring insulin Injecting insulin Determining insulin dose
- Independently operating insulin pump
- Other: _____

Other Instructions:

Health Care Provider's Signature: _____ Phone: _____ Date: _____

Parent's Signature: _____ Phone: _____ Date: _____

Order reviewed by camp nurse: _____ Date: _____