

CAMP FLOYD ROGERS
INSULIN PUMPER INFORMATION

Fill out form and bring with you opening day SATURDAY

Camper's Name _____ Last Site Change _____

(Write in during registration)

Pump Type & Model _____ Pump Serial No. _____
(Example: Minimed722 or Animas1250)

How long has child had diabetes? _____ How long has he/she worn an insulin pump? _____

What type of infusion set is worn? _____

Who changes the site? _____ Who refills the pump? _____

Who changes basal rates? _____

List 24 hour Basal rates (in units per hour):

Does your child know how to use a temporary basal rate? _____

Who boluses? _____ How are bolus rates determined? (Please use an additional sheet of paper if needed.)

Does the child perform pump and infusion set operations independently, including cleansing the site, refill & priming the pump, inserting the infusion set, determining bolus rates, programming & activating bolus, programming basal rates, disconnecting, reconnecting, and responding to the pumps alarms? _____

On a separate sheet of paper, please list:

A) The pump operations your child performs without instruction. Also, please list the operations your child performs with assistance.

B) The steps you follow in changing a site.

C) What you clean with, any special tape or solutions used and the type of infusion set used. (There are many different products used with pump therapy and we want to make sure that we use the correct products for your child when changing sites.)

What is the normal frequency of your child's site change? _____

Does your child ever resist having site changes? _____

When your child's site is changed, what amount of insulin is bolused into the empty cannula? _____

Does your child use Emla or other numbing agent for site changes? _____

Please list the numbing agent. _____

OVER

Camper's Name _____

Does your child have a carbohydrate ratio(s)? _____ Please list it/them:

Breakfast

Lunch

Supper

Snacks

Can your child accurately count carbohydrates? _____

On a separate sheet of paper, please explain:

How you or your child calculates a meal or snack bolus. If the child is dependent on an adult to calculate the bolus, please state that as well.

Does your child have a supplemental blood glucose correction formula or sliding scale?

Additional Insulin for high blood glucose — 2 options:

A) Supplemental insulin for blood glucose (BG) over _____ by this formula:

Blood Glucose Level

minus Target Blood Glucose _____ = _____ divided by _____ = _____ Units of _____
(correction factor) (Type of Insulin)

Or

B) Sliding scale with _____ insulin as below in units:

(Type of Insulin)

101-150 151-200 201-250 251-300 301 - 350 351 - 400 401-500 Over500

On the average, how many times a day does your child check his/her blood sugars? _____ times a day.

Please provide as much information as possible regarding the child's use of his/her insulin pump. This information is very useful to our physicians as they monitor the child's blood glucose levels and write insulin administration orders. Camp physicians prefer to minimize adjustments to basal or bolus rates but may make minor adjustments if out of range blood glucose levels indicate a need for adjustment.

Additional Information: _____

NO CHANGES TO BASAL RATES OR BOLUS GIVEN OR SITE CHANGES OR ANY KIND OF CHANGES TO PUMP, UNLESS SUPERVISED AND RECORDED BY MEDICAL STAFF.
SIGNATURE OF CAMPER _____ **DATE** _____
SIGNATURE OF PARENT _____ **DATE** _____

CAMP FLOYD ROGERS Enriching lives, building tomorrows P.O.Box 31536 Omaha, NE 68131

THIS COMPLETED IS TO BE BROUGHT TO CAMP ON OPENING DAY