Reviewed by camp staff
(Initial)_____Date_____

Diabetes Management for RVR Health Services

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 or legal guardian.

Participant's Name:_____**DOB**_____**Camp/Program**_____

1. Authorized Health Care Provider Verification:
The participant can self-perform the following:
□ Blood glucose testing □ Measuring insulin
□ Injecting insulin □ Determining dose
□ Operating insulin pump □ Other_____
(Self-performance of these tasks will be observed and monitored using a double check system between the camper and either an RN or a Certified Medication Technician).

2. Blood Glucose Testing: (check all that apply)
Target range *for blood glucose at camp*_____
□ AC and HS □ AC, PC & HS
□ PC and HS □ Before snacks
□ At camper's discretion □ Other_____

3. Snack times: (check all that apply)
□ Mid morning □ Afternoon
□ Bedtime □ Other_____

4. Insulin Orders:
Short acting:
Brand name and type:_____
Administration times: (check all that apply)
□ AC and HS □ AC, PC & HS
□ PC and HS □ Before snacks
□ Other_____
Insulin Administration via:
□ Syringe and vial □ Insulin pump
□ Insulin pen □ Other_____
Insulin Dosing:
Written Sliding Scale as follows:
Blood Glucose_____to_____=_____units
Blood Glucose_____to_____=_____units
Blood Glucose_____to_____=_____units
Blood Glucose_____to_____=_____units
Blood Glucose_____to_____=_____units
Blood Glucose_____to_____=_____units

□ *Add Carb calculation insulin dose to Sliding Scale*

Insulin to carbohydrate ratio:
_____unit(s) insulin per_____Carbs (gms)

Long acting:
Brand name and type:_____
Dose/Route:_____
Administration time(s):_____

Additional Orders/Notes

5. Hypoglycemia:
- Treatment for mild lows: *from*_____*to*_____
- Treatment for moderate lows: *from*_____*to*_____
- Treatment for severe lows with unconsciousness

6. Hyperglycemia:
□ If blood glucose >_____initiate insulin orders
□ If blood glucose >_____or exhibit symptoms of ketosis, check urine ketones.
□ Other:_____.

Doctor's stamp

Doctor's Signature:_____**Date**:_____

I understand that any child with a chronic health condition is more at risk in a new environment to have changes in their health status. I have been informed that the camp health center is a basic first aid station and NOT equipped for medical emergencies of a catastrophic nature. I'm aware that River Valley Ranch has physician approved emergency protocols in place for treatment of hypoglycemia and hyperglycemia. These protocols will be initiated in the event the above orders do not improve the status of my child's condition. I know my child has a pre-existing condition and I will fully accept any financial responsibility incurred as a result of a decision by the staff of River Valley Ranch to seek outside medical attention. I agree to allow my child to attend camp with the knowledge I have of my child's condition and the camp setting. I further understand that non-compliance with Doctor's orders and/or camp policies will result in my child's dismissal from camp without refund. I also agree to provide the necessary supplies and equipment needed for treatment.

Parent/guardian signature:_____ Date:_____

Adapted from: a PADRE Foundation diabetes form