

NEJEDA DAY CAMP INTAKE FORM

This form must be filled out by the camper's endocrinologist within 3 weeks of the start of camp.

NAME: _____ AGE: _____ ALLERGIES: _____ YEARS WITH DM: _____ SPEC # _____

SEIZURES/DKA/OTHER PROBLEMS: _____ PARENT CONCERNS: _____

SCHEDULED SNACK? _____ PERTINENT HEALTH HISTORY: _____ A1C _____

HEIGHT: _____ WEIGHT: _____

CHECK INSULIN TYPES:

<input type="checkbox"/> HUMALOG	<input type="checkbox"/> LANTUS	TIME OF DAY _____
<input type="checkbox"/> NOVOLOG	<input type="checkbox"/> LEVEMIR	TIME OF DAY _____
<input type="checkbox"/> APIDRA	<input type="checkbox"/> BASAGLAR	TIME OF DAY _____
<input type="checkbox"/> TRESIBA	<input type="checkbox"/> NPH	_____ UNITS @ _____
<input type="checkbox"/> FIASP		

TARGET: _____

(IF RANGE, USE HIGHEST AT HOME)

CORRECTION FACTOR: _____

(SENSITIVITY, ISF, INS:GLUCOSE RATIO)

INSULIN CARB RATIOS:

OR

AM: _____

LUNCH: _____

PM: _____

PLEASE PROVIDE PRE-PRINTED CHEAT SHEETS

OR INSULIN SCALES, IF USED AT HOME

OTHER MEDICATIONS (I.E. INHALERS)

PHYSICIAN SIGNATURE: _____

DATE: _____

PRINT NAME & PHONE OF MD OR STAMP: _____

CIRCLE INSULIN DELIVERY METHOD:

PUMP – BRAND: _____ SERIAL # _____

CGM – BRAND: _____

SYRINGE/PEN – NEEDLE SIZE: _____

INSULIN SLIDING SCALE TO CORRECT HIGH SUGARS:

BLOOD SUGAR RANGE UNITS OF INSULIN

PRIMARY CONTACT: _____

RELATIONSHIP TO CAMPER: _____

PHONE NUMBER: _____

PARENT/GUARDIAN SIGNATURE: _____

REVIEWED & UPDATED WITH PARENT ON FIRST DAY:

NURSE'S SIGNATURE: _____

DATE: _____

