

CAMP NEJEDA BFF INTAKE FORM

THIS FORM MUST BE FILLED OUT BY THE CAMPER'S ENDOCRINOLOGIST
WITHIN 3 WEEKS OF THE START OF CAMP



NAME: _____ AGE: _____ ALLERGIES: _____ SPEC #: _____

YEARS WITH DM: _____ SEIZURES/DKA/OTHER PROBLEMS: _____

PARENT CONCERNS: _____ A1C: _____

HT: _____ WT: _____ BP: _____ PERTINENT HEALTH HISTORY: _____

INSULIN TYPE: Humalog/Admelog/Lyumjev Novolog Apidra Fiasp

CGM – BRAND: _____ **CLP:** Y / N

IF ON A PUMP – BRAND: _____

Basal Start Time	Basal	Ratio Start Time (if different)	Meal	Carb Ratio	Correction Factor	Target	(If range, use highest at home)
12 AM							

IF ON A PEN OR SYRINGE – NEEDLE SIZE: _____ Please provide insulin scales if used at home

LONG-ACTING INSULIN: Lantus Levemir Basaglar Tresiba **DOSAGE:** _____ **TIME OF DAY:** _____

Time Periods:	Target	Insulin: glucose	Insulin: carbs	Long Acting
Breakfast				
Lunch				
Snack				
Supper				
Bed				

OTHER MEDICATIONS (I.E. INHALERS/EPI-PENS):

PROVIDER'S SIGNATURE: _____ **DATE:** _____

PRINT NAME & PHONE OF MD OR STAMP: _____

PRIMARY CONTACT: _____ **RELATIONSHIP TO CAMPER:** _____

PHONE NUMBER: _____ **PARENT/GUARDIAN SIGNATURE:** _____

REVIEWED & UPDATED WITH PARENT ON INTAKE – NURSE SIGNATURE: _____