

CHILD'S NAME: _____ CAMP DATE _____

CAMP DESALES: DIABETES FORM

Please complete only if your child has diabetes. Attach to medical form.

Your child will be responsible for managing their diabetes while at camp. Health Office staff will provide support including menu carb counts. Please note that we do not have diabetes educators or specialists on staff. Call 517-414-0784 for any questions.

DIABETES EXPECTATIONS

CAMP DESALES programs take place in the outdoors and your child will be more physically active than they are at home. The closest hospital, Henry Ford Allegiance Hospital in Jackson, MI, is approximately 30 minutes away.

It is our expectation that your child is capable of self-managing their diabetes: comfortable with counting carbs, recognizing if they are high or low, injecting insulin, etc. Children with insulin pumps are expected to be familiar with their pump and be able to manage pump malfunctions, changing sites and replacing tubing. Your child will carry their supplies and snacks with them while at camp. Extra supplies and snacks can be stored at our Health Office.

DIABETES INFORMATION

When does your child check their blood sugar levels?
What is your child's typical range for blood sugar readings?
When does your child inject insulin? Please include what type of insulin is used and how many units.
How often does your child have a HIGH blood sugar reaction?
Please list what signs or symptoms your child presents with when their blood sugar is HIGH as well as how it is managed.
How often does your child have a LOW blood sugar reaction?
Please list what signs or symptoms your child presents with when their blood sugar is LOW as well as how it is managed.
Has your child ever had a severe low blood sugar reaction (seizures, loss of consciousness, etc.)? <input type="checkbox"/> Yes * <input type="checkbox"/> No *If yes, please give details.

DIABETES MEDICATIONS

Please list all routine and emergency diabetes medications your child will be bringing to camp in the MEDICATION INFORMATION section of your child's health form. A refrigerator and sharps container are available at our Health Office.

COMMUNICATION AND TREATMENT PROTOCOL

At what point should we notify you (parent/guardian) about your child's blood sugar level?		
At what point should your child be taken to a physician or hospital?		
Please give any other information you would like our staff to know about your child's diabetes management plan. Attach additional information as needed.		
Parent/Guardian Name	Relationship to Child	Phone Number

Parent/Guardian Signature _____ Date: _____