PARENT REQUEST for Completion of 2016 Summer Camp Forms

*****WE NEED YOU TO ANSWER ALL QUESTIONS TO BE ABLE TO COMPLETE YOUR CHILD'S CAMP FORM!!!*****

Please return this Request Form to us along with any forms that have been provided by your child's camp.
Request Forms may be submitted by email: BerriePeds@cumc.columbia.edu or fax 212-851-5493.

Child's Name: ______________________________ Date of Birth:__________________ Date of Diagnosis:________________

1) ***Does your child have any allergies to medications or foods?*** □ **YES** □ **NO If yes, please list: ______________________________**
2) **Who is your child's doctor?** □ **GANDICA** □ **LEIBEL** □ **SOFTNESS** □ **VARGAS** □ **OTHER: ______________________**
3) **Does your child need supervision to check their blood sugar?** □ **YES** □ **NO**
4) **Does your child need supervision to give insulin?** □ **YES** □ **NO**
5) **What kind of rapid-acting insulin does your child use?** □ **Novolog** □ **Humalog** □ **Other: ___________**
6) **What device does your child use to administer rapid-acting insulin?**

   □ **INJECTIONS with:** □ **Syringes** *or* □ **Disposable Pens** *or* □ **Half-Unit Pen Devices** (ex. *Luxura* or *Echopen*)

   OR

   □ **INSULIN PUMP (BRAND________________________) with: _____________________ infusion set** (ex. *Quickset 6mm*, *Inset 90*, etc.)

7) **Choose ONE SECTION below (Section A for injection regimens *OR* Section B for pumps) and enter your child's rapid-acting insulin doses**

□ **SECTION A** – FOR PEOPLE USING **PENS/SYRINGES**							□ **SECTION B** – FOR PEOPLE USING **PUMPS**							
Definitions for calculations	**Carbohydrate Ratio(s)**		**Correction Factor(s)**		**Target BG(s)**		**Basal Rate(s)**		**Carbohydrate Ratio(s)**		**Correction Factor(s)**		**Target BG(s)**	
	TIME	RATIO	TIME	RATIO	TIME	BG	TIME	RATE	TIME	RATIO	TIME	RATIO	TIME	BG
	12MN		12 MN		12MN		12MN		12MN		12 MN		12MN	
$\frac{\#\ of\ Carbs}{Carb.Ratio}$														
$\frac{BG - Target}{Corr.Factor}$														

8) **Does your child also take long-acting insulin (Lantus or Levemir)?** □ **YES** □ **NO**

   IF YES, circle one: Lantus *or* **Levemir and ENTER DOSE: _____________ and TIME TO BE GIVEN: _____________ AM/PM**

9) **Does your child need any other medications?** □ **YES** □ **NO**

   If YES, please list medication(s) and medical condition(s): ____

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