DIABETES MANAGEMENT FORM – CINCINNATI MUSEUM CENTER CAMPS
May 27 – August 8, 2025

Camper Name: _____ Age: _____

We want your child to receive appropriate support for their diabetes diagnosis while attending CMC camps. All medications will be stored and administered in accordance with CMC policies. We are happy to work with you to try to accommodate your camper's need as much as possible.

Medical Provider's Name and Title: _____

Medical Provider's Place of Employment: _____

Medical Provider's Address: _____

Medical Provider's Telephone: _____

Medical Provider's Signature: _____ Date: _____

1. **Authorized Medical Provider Verification:** *The camper can <u>self-perform</u> the following:* (check all that apply)
   - ❑ Blood glucose testing ❑ Measuring insulin
   - ❑ Injecting insulin ❑ Determining dose
   - ❑ Operating insulin pump ❑ Other_____

2. **Blood Glucose Testing:** (check all that apply)
   ***Target range** for blood glucose at camp:*_____
   - ❑ Before meals (AC) ❑ Before meals (AC) & After meals (PC)
   - ❑ After meals (PC) ❑ Before snacks
   - ❑ At camper's discretion ❑ Other _____

3. **Snack times:** (check all that apply)
   - ❑ Mid-morning ❑ Afternoon
   - ❑ Other _____

4. **Insulin Orders:**
   ***Short acting*:** _____
   Brand name and type: _____
   ***Administration times*:** (check all that apply)
   - ❑ Before meals (AC) ❑ Before meals (AC) & After meals (PC)
   - ❑ After meals (PC) ❑ Before snacks
   - ❑ Other _____

   Insulin Administration via:
   - ❑ Syringe and vial ❑ Insulin pump
   - ❑ Insulin pen ❑ Other _____

   Blood Glucose _____ to _____ = _____ units
   Blood Glucose _____ to _____ = _____ units
   Blood Glucose _____ to _____ = _____ units
   Blood Glucose _____ to _____ = _____ units
   Blood Glucose _____ to _____ = _____ units
   Blood Glucose _____ to _____ = _____ units

   ***Insulin Dosing**:*
   - ❑ 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):_____

_____

_____

_____

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 greater than _____, then initiate insulin orders
❑ If blood glucose greater than _____, or the camper exhibit's symptoms of ketosis, call parent/legal guardian or emergency contact and if necessary, call 9-1-1.
❑ Other: _____

Additional Orders/Notes: _____

_____

_____

_____

_____

Parent/Legal Guardian Authorization and Release

I, _____, hereby authorize the CMC camp medical coordinators and/or camp staff members to administer the medication listed above or to supervise the camper in self-administration of such medication. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility.

I, on behalf of myself, my executors, administrators, heirs, next of kin, and successors, hereby covenant to hold harmless and indemnify the CMC and all of its officers, departments, agencies, agents, and employees from any and all claims, losses, damages, injuries, fines, penalties, and costs (including court costs and attorney's fees), charges, liabilities, or exposures, however caused, resulting from, arising out of, or in any way connected to assisting the above named camper with the use of asthma medication. I have read and understand this Authorization and Release and by my signature I agree to its terms.

Parent/Legal Guardian Signature: _____ Date: _____

Please notify us immediately of any changes on this form by contacting the Museum Camp Manager via phone at (513) 728-0082 or email at camps@cincymuseum.org.