2026 Kids for a Cure Club Day Camp

Physician's Approval and Orders - Pump

Child's Name: _____ DOB/Age: _____

The child listed above is my patient and I have been treating him/her for diabetes since: _____
I certify this child is physically fit to participate in all the activities of "Kids for a Cure," the Diabetes Day Camp being co-sponsored by Mary Washington Healthcare Diabetes Management Program.

Insulin type: _____ Insulin pump type: _____
*Dosing to be determined by Bolus Calculator in insulin pump or smart pen/meter unless moderate or large ketones are present or in the event of device failure.
Infusion Set: _____

Please attach a printout of pump settings **OR** fill in the settings below. If settings change after this form is completed, please provide a printout of the most current settings to be used for bolus calculations in case of device failure.

Basal rates: _____
_____
_____

Is CGM used for dosing? YES NO

Target blood sugars: _____

Correction Factor(s): _____

Please Circle YES or NO		
Is Insulin Given for Snack?	YES	NO
Is A Correction Given for Snack?	YES	NO
Is Insulin Given for Lunch?	YES	NO
Is A Correction Given for Lunch?	YES	NO

Insulin to CHO ratios: _____

Other orders or comments about patient care: _____
_____
_____

***Temporary Basal/Bolus pump adjustments for activity during camp may be made by CDCES**

Physician Signature: _____ Date: _____
Physician's name/ Address/phone (please print)
_____
_____

Orders must be signed and received by March 31, 2026 for child to attend camp.