

For Sitter: About the Parents, Child with T1D, Other Children

Names:

Mother _____ Father _____ Other _____

Contact information and preferences:

This home's address _____

Cross-streets to tell a 911 operator _____

This home's phone number _____

Phone number of location where parent(s) will be (if available) _____

Mother **Father** **Other (check one):**

Preferred method of contact _____

Phone (number) _____ Phone (number) _____ Text (number) _____

Mother **Father** **Other (check one):**

Preferred method of contact _____

Phone (number) _____ Phone (number) _____ Text (number) _____

Name of child with diabetes _____

Names of other children and ages

Emergency contact (if parents cannot be reached):

Relation to child _____

Name _____

Contact information _____

Diabetes Self Care Activities by the child with T1D:

Diabetes Self Care Activities by the child with T1D:

The child:	Can do	Needs help	Can't do
Check blood glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Check blood ketones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Check urine ketones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Count grams of carbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calculate an insulin dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prep insulin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The child:	Can do	Needs help	Can't do
Choose injection site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inject insulin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bolus on pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suspend/disconnect pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insert Pod or infusion set	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does child wear/use a continuous glucose monitor (CGM)? _____

How do sitter and parent view CGM results? _____

Before physical activity blood sugar needs to be above _____ and not higher than _____

Does child/family have a blood glucose record where they keep results? _____

Contact parent with each BG reading? Yes No

Child's usual signs and symptoms of low blood glucose _____

Can child feel low blood sugar? Yes No

Sitter should give glucagon if child has these signs and symptoms _____

High blood glucose symptoms child experiences _____

Directions to calculate a correction dose of insulin:

Blood glucose ____ minus target _____ divided by correction factor _____ = dose _____ *Example:*

BG 250 minus Target 150 divided by correction factor 50 = 2 units

Directions to calculate an insulin dose for food based on insulin to carbohydrate ratio:

Amount of carbs eaten _____ divided by carb ratio _____ = dose _____

Example: 45 grams of carbohydrates divided 20 carb ratio = 2.5 units

Add the correction and insulin dose for food together for the total dose.

Round up or down at _____ Preferred injection sites _____ When to call 911 _____

About the Child with T1D:

What activities does child like? _____ What calms child down? _____

Routines when giving insulin or checking blood glucose _____ When, if any, is nap? _____

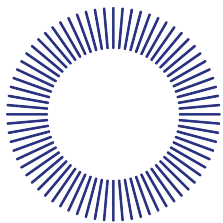
When is bedtime? _____ What are child's routines? _____

When can child call parent? _____ When should sitter call parent? _____

Other health concerns or issues? _____

Sitter is knowledgeable about and demonstrates use of:

- Blood glucose meter Continuous glucose monitor and CGM graph Insulin pen or syringe
- Give a bolus dose from pump or Pod and PDM Disconnect infusion set from pump and reconnect
- Suspend an insulin pump or Pod and PDM Glucagon injection
- How to calculate insulin dose (using insulin-to-carbohydrate ratio and correction dose)



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