Addendum B
Travelers with Insulin-Controlled Diabetes

Traveler's Name _____ City and State _____

Exact name and brand of insulin used: Short acting: _____

Long acting: _____

The insulin is delivered via: _____Pen _____Syringe

Is insulin coverage for lunch taken: ____ BEFORE or ____ AFTER the meal?

Target blood glucose: Pre-Meal: _____mg/dl; 2 hours after meals: _____ mg/dl

Insulin Coverage for: Meals, Snacks & Long Acting Insulin

Meal/Snack	Time	Insulin: Carb ratio	Carb grams per meal	Type of insulin	Units of insulin	Is sliding scale present?
AM						☐ Yes ☐ No
Breakfast						☐ Yes ☐ No
AM Snack						☐ Yes ☐ No
Lunch						☐ Yes ☐ No
PM Snack						☐ Yes ☐ No
Dinner						☐ Yes ☐ No
Bedtime						☐ Yes ☐ No
Night						☐ Yes ☐ No

Sliding Scale

Sliding Scale: The amount of insulin used to cover an elevated blood glucose **over** the amount of insulin used to cover meals.

Correction Factor (Blood Glucose – Target ÷ Sensitivity
Formula (if used) (Blood Glucose - _____ ÷ _____)

If Blood Glucose is less than _____ mg/dl = Give **NO Sliding Scale Insulin**

Blood Glucose _____ to _____ mg/dl give _____ Units

Blood Glucose _____ to _____ mg/dl give _____ Units

Blood Glucose _____ to _____ mg/dl give _____ Units

Blood Glucose _____ to _____ mg/dl give _____ Units

Blood Glucose _____ to _____ mg/dl give _____ Units

Blood Glucose above _____ mg/dl give _____ Units

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