מרכז שניידר לרפואת ילדים
مركز شنايدر لطب الاطفال
Schneider Children's Medical Center

CLALIT HEALTH

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Date:_____

TO WHOM IT MAY CONCERN

This is to confirm that _____
born ___/___/___ is under our care because of Type 1 (Diabetes Mellitus).

He / She is treated by:

1. ____daily insulin injections

Morning: _____

Noon: _____

Evening: _____

Night: _____

2. Insulin pump therapy:

Pump:_____ Insulin _____

The insulin's are _____ preparations, _____ units/ml.

In case of malfunction should use in long acting insulin_____

3. A continuous glucose sensor and accessories
4. He / She should have in his / her possession: vials of insulin, syringes, alcohol, glucagen hypokit (to be used in case of severe hypoglycemia) and 100 ml of sweetened beverage to be used in case of hypoglycemia, the apparatus for blood tests, pump supplies, etc.

Sincerely,

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