Camper _____________ _______________ Birth date ______ Sex__ Session(s)________
Last Name First Name

Health Form
(Completed By Health Care Professional)

Last Physical Exam: Date _____/______/_________

Child's Height: _____________cm/in Weight: ____________kg/lb BP: ____________/_________________

Physical Exam Normal for Child's Age? Yes No

Child has had: ___Rubella ___Mumps ___Chicken Pox ___Rubeola

Other Illnesses:____

Surgeries:____

Medication Allergies:____

Immunizations (Give Dates): Tetanus:___________ T.B.___________ Pos___ Neg___

If tetanus date is not available, medical personnel will be allowed to administer a tetanus shot.

Home Glucose Meter Used:____

Value of Child's Last A1c: ___________________________ Date: ____/_____/__________

How would you rate this child's diabetes control? Good Fair Poor
This child is compliant with dietary management? Yes No
This child is compliant with insulin management? Yes No
Child checks blood glucose: Frequently Average Rarely
Child needs extra supervision with diet, insulin, checking: Yes No

Children will be supervised with above listed procedures.

Circle all that apply: Child is prone to

*Ketoacidosis *Hypoglycemia *Unrecognized Hypoglycemia *Hypoglycemic Seizures *Nocturnal Hypoglycemia

Please Circle All that Apply:
Insulin Make: Lilly Novo Aventis Other___________________
Insulin Type: Regular Humalog Novolog Lantus NPH Levemir Lente
Other____________________________
Insulin Doses: AM______________ Noon_____________ Supper_____________ Bedtime_______________
Injection Type: Pen Pump Syringe

Please Note Any Abnormal Findings:
H.E.E.N.T.____
Chest/Cardiac____
Abdomin____
Extremities____

Neurological____
Condition of Injection Sites____

Does the child have any other chronic condition, illness, or disease other than diabetes? Yes No
If yes, explain:____

List any medications: Medication Dose Time Administered

____
____
____

I approve of this child attending camp? Yes No
During the child's stay at camp, s/he will be monitored as closely as conditions permit. Every effort will be made to maintain your basic management program; however, minor changes are often needed in dosage or diet due to the level of activity to maintain optimal control. If you wish that no altercations are made during camp, please indicate below.

_____I approve that medical staff may make changes to my patient's dosages/diet.
_____I do not want changes in dosages/diet made for my patient except for hypoglycemia.
_____I approve that dosages/diet changes be made, but return to original after camp.

Physician's Signature_____________________________________ Date___________________
Physician's Printed Name____
Address____
Phone___________________________________ Fax_________________________________
Email____

This form must be turned in for camper acceptance. Physicians, ***please fax completed forms to 317-877-1846.***
May also be mailed to DYFI, 817 S. Tibbs Ave, Indianapolis, IN 46241.

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