DYFI Camp Health Form (Completed by Health Care Professional)

Date: _____/_____/_____

Name: _____ DOB:_____

Child's Height: _____(in) Weight: _____(lbs.) BP _____/_____

Physical Exam:

H.E.E.N.T._____

Chest/Cardiac_____

Abdomin_____

Extremities_____

Neurological_____

Condition of Injection Sites_____

Physical Exam Normal for Child's Age? Yes_____ No _____

Immunization Date (s):

DPT (Diphtheria, Pertussis, Tetanus) _____Tetanus Booster _____ Polio_____

MMR (Measles, Mumps, Rubella)_____ HIB (Haemophilus Influenza B) _____

Varicella (Chicken Pox) _____ Hepatitis B _____ Pneumococcal (PCV13) _____

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

Current and Past Medical History

Has the camper have a history of or is prone to any of the following (Please circle all that apply).

1. Recent illness or infectious disease
2. Asthma
3. Frequent Ear Infections
4. Seizure Disorder or Convulsions
5. Heart Defect/Disease
6. Hypertension
7. Bleeding/Clotting Disorders
8. Mononucleosis (in last 12 months)
9. Joint problems (knees, ankles)
10. ADHD or ADD
11. Fractures
12. Frequent headaches
13. Head injury/concussion
14. Eating disorder
15. Diarrhea or constipation
16. Hospitalization
17. Sleep walking
18. Bed wetting
19. Depression or anxiety
20. Autism
21. Celiac
22. Eczema
23. Hypothyroid
24. Hyperthyroid
25. Hearing impairment
26. Other _____

Please give more information about the circled items below:

_____

_____

_____

Surgeries: _____

Allergies: _____

Daily medications other than insulin (Medication Dose & Time Administered):

Name of Medication	Reason for Taking	Dose of Medication	Administration Time

Diabetes History:

Home Glucose Meter Used:_____

Child's Last A1c: _____ Date Taken: _____

How would you rate this child's diabetes control? Good Fair Poor

Child checks blood glucose: _____ twice a day _____ three times a day _____ 4 or more times a day

Child needs extra supervision with (Circle) Diet Insulin Checking Other_____

Children will be supervised with above listed procedures.

Circle all that apply: Child is prone to

*Ketoacidosis *Hypoglycemia *Unrecognized Hypoglycemia

*Hypoglycemic Seizures *Nocturnal Hypoglycemia

Circle All Insulin Types that Apply:

*Humalog *Novolog *Apidra *Fiasp *Regualr *Admelog

*Basaglar *Tresiba *Lantus *Levemir *Toujeo *NPH

*Other: _____

Insulin Doses: Breakfast_____ Lunch_____ Supper_____ Bedtime_____

Injection Type: *Pen *Syringe *Pump (Type: _____)

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 of medical staff making changes to my patient's dosages/diet.
_____I do not want changes in dosages/diet made for my patient unless it is for hypoglycemia.
_____I approve the dosages/diet changes made, but prefer the child return to original after camp.

Physician/Provider's Signature_____ Date_____
Physician/Provider's Printed Name_____
Address_____
Phone_____ Fax_____
Email_____

This form must be turned in for camper acceptance.

Physician/providers, completed forms can be emailed to dyfiemily@gmail.com
Or fax to 317-877-1846
or mailed to DYFI, 5050 E. 211th St. Noblesville, IN 46060

DYFI Medical Director

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