CAMP NEJEDA
Est. 1958
WHERE CHILDREN WITH TYPE 1 DIABETES CAN BE THEMSELVES

HEALTH HISTORY AND PHYSICIAN EXAMINATION – 2017

For All Staff (with or without Diabetes) and Campers without Diabetes

Name_____ Birth Date _____ Sex ____ Age ____
(Last) (First) (MI)
Home Address_____
Email Address _____
Parent or Guardian_____ Phone(s)_____

If not available in an emergency, notify: Name _____

Relationship _____ Phone(s) _____

HEALTH HISTORY

Diabetes
Kidney Disorder
Frequent Ear Infections
Hypertension
Chicken Pox
Heart Defect/Disease
Asthma
Smoking
Bleeding/Clotting Disorder
Hepatitis
Mononucleosis
Convulsions/Seizures most recent date: _____
Psychiatric Treatment details: _____
_____

ALLERGIES

Insect Stings
Hay Fever
Penicillin
Latex

Other Drugs: _____

Other (foods, plants): _____

Operations or serious injuries (include dates) _____

Disability, chronic or recurring illness or medical condition (other than diabetes) _____
_____

Do you take any medication other than insulin? _____
If yes, list the name of medicine, times and doses (be specific)

Medication (attach sheet if needed)	Dose	Time
_____	_____	_____
_____	_____	_____

Name of Primary Physician: _____ Phone: _____

Name of Endocrinologist: _____ Phone: _____

Please notify the camp if you have any illness in the three weeks prior to camp.

YOU MUST BRING YOUR INSURANCE CARD TO CAMP AT INTAKE TO BE PHOTOCOPIED.
Name of Subscriber _____ Subscriber's Date of Birth _____
Subscriber's Employer _____ Subscriber's Occupation _____

Please Note: YOU ARE NOT ALLOWED IN CAMP WITHOUT A COPY OF YOUR IMMUNIZATION RECORD FROM YOUR DOCTOR OR SCHOOL. If records are already on file, only updates are required (including tetanus).

Staff signature_____ Date_____
(A parent/guardian signature is ALSO required (on the back of this form) for any staff member who will not yet be 18 on the day that staff orientation starts.)

CONTINUED ON BACK

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Parent/Guardian consent for staff members who are minors

I give consent to the administration of insulin and whatever other medical care may be deemed necessary while at camp. In case of MEDICAL EMERGENCY, I understand every effort will be made to contact the staff person's parent(s) or guardian(s). I do hereby state that I am the parent/guardian having legal custody of: _____ a minor, age _____
I authorize Camp Nejeda to consent to any laboratory or X-ray examination, anesthetic, medical or surgical treatment and hospital care to be rendered to my child under the supervision of a licensed physician. I hereby release the camp from any liability for any accident or injury to said child occurring at camp or on a camp-sponsored trip off the site. Forms may be photocopied as necessary.

Signature _____ Date_____

Printed Name_____ Relationship to Camper_____

FOR COMPLETION BY PHYSICIAN:

Name_____ Birth Date _____ Sex ____ Age ____

Date of Last Exam _____ (must be within the past 12 months)

Height_____ cm / in Weight_____ kg / lb B/P_____

Other pertinent physical findings_____

Medication Allergies_____

Other Medical Problems (such as Epilepsy) _____

Any other Medications (specify dosages to be continued at Camp) _____

_____

For those with diabetes:
Date of Last HbA1c _____ result _____ (Normal range _____)

History of DKA, Nocturnal Hypoglycemia, Hypoglycemia Requiring Glucagon or IV Glucose: (Please include dates) _____

Do you know of any physical or emotional disability which might create a problem or require special accommodation for him/her being a staff member at camp?

Details: _____

Licensed Physician's Signature _____

Date of Completion: _____ By: _____ (if completed by nurse/asst.)

Please print the following:
Name of Physician _____ Telephone: _____

Address: _____

City, State, Zip _____