



WHERE CHILDREN WITH TYPE 1 DIABETES CAN BE THEMSELVES

HEALTH HISTORY AND PHYSICIAN EXAMINATION – 2017

For All Staff working Day Camps Only or Less Than Three Nights

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

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

ALLERGIES

<input type="checkbox"/> Insect Stings	Other Drugs: _____
<input type="checkbox"/> Hay Fever	Other (foods, plants): _____
<input type="checkbox"/> Penicillin	
<input type="checkbox"/> Latex	

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



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 Nejedra 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** _____