

Camp Until A Cure

Diabetes Youth Foundation Camp - Noblesville, IN
Physician's Medical Information - Due by May 15th
PHYSICIAN IS TO FILL OUT THE ENTIRE FORM

CHILD'S NAME: _____

CHILD HAS HAD: Rubella Mumps Chicken Pox Rubeola

Other illnesses _____

Surgeries _____

Medication Allergies _____

Immunizations (Give dates) Tetanus _____ T.B. _____ Pos Neg

Home Glucose meter used: _____

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

Do you feel that the child is compliant with dietary management? Yes No

Do you feel that the child is compliant with insulin management? Yes No

Does child test his/her blood sugar regularly at home? Yes Some No

Does child need extra supervision with insulin, testing or diet? Yes No

****ALL CHILDREN ARE SUPERVISED WITH THESE PROCEDURES AT CAMP****

Value of child's last A1c _____ Date: ____/____/____

****A1C is REQUIRED for acceptance**

- Child is prone to Ketoacidosis
- Child is prone to Hypoglycemia
- Child is prone to UNRECOGNIZED Hypoglycemia
- Child is prone to Hypoglycemic seizures
- Child is prone to nocturnal Hypoglycemia

Please circle those that apply

Insulin Make Lilly Novo Aventis Other _____

Insulin Type Regular Humalog Novolog Lantus
NPH Lente Levemir Other _____

Insulin Doses AM _____ Noon _____
Supper _____ Bedtime _____

Injection type Syringe Pen Pump

Last Physical Exam

Date of Exam ____/____/____

Height _____ cm / in Weight _____ kgs / lbs Blood Press _____ / _____

Physical Exam is completely normal for age Yes No

Please note any abnormal findings below

H.E.E.N.T. _____

Chest/Cardiac _____

Abdomen _____

Extremities _____

Neurological _____

Condition of injection sites _____

Camper Name: _____

Does the child have any other chronic condition, illness or disability other than diabetes

Yes No

If yes, explain _____

List any medications below

Medication

Dosage

Times to be given

Medication	Dosage	Times to be given

I approve of this child attending The Camp for Children with Diabetes

During the child's stay at camp, he/she will be monitored as closely as conditions will 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 alterations are made during camp, please indicate below.

I approve that the Medical Staff may make changes in my patient's dosages/diet

I do not want diet/dosage changes made in my patient's diet/insulin during camp except for hypoglycemia

I approve that diet/dosage changes can be made, but return to original after camp

Physician's Signature _____ Date ____/____/____

Physician's printed name _____

Address _____

Phone _____ Email _____

Fax # _____

****PLEASE RETURN THIS FORM NO LATER THAN MAY 15TH or 2 weeks before camp****

****This FORM must be turned in for camper acceptance****

Physicians, PLEASE fax these sheets to the camp office ASAP at 317-243-4488

PLEASE MAIL TO DYF Camp, 817 South Tibbs Ave, Indianapolis, IN 46241 or fax 317-243-4488