

RETURN TO:

The Barton Center for Diabetes Education, Inc.

Att. Camp Director, P.O Box 356, 30 Ennis Road, North Oxford, MA 01537 Tel: (508) 987-2056 FAX: (508) 987-2002

www.bartoncenter.org

HEALTH EXAMINATION FORM FOR STAFF/CAMPERS

CAMPER/STAFF NAME: _____ BIRTH DATE: _____ AGE: _____

CAMPER/STAFF HOME ADDRESS _____ Cell: _____
Phone: _____

PARENT/GUARDIAN NAME: _____

Address if different: _____

PHONE NUMBERS WHERE PARENT/GUARDIAN CAN BE REACHED DURING THE CAMP SESSION
(Home) _____ (work) _____ (cell) _____ (e-mail) _____

In an emergency contact _____ at _____

PLEASE PROVIDE A COPY OF YOUR HEALTH INSURANCE CARD and IMMUNIZATION RECORD.

HEALTH HISTORY (Check all that apply and give approximate dates)

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures | <input type="checkbox"/> Medication Allergies |
| <input type="checkbox"/> Bleeding/Clotting Disorders | <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Environmental Allergies |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Food Allergies |
| <input type="checkbox"/> Attention deficit | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Learning or developmental disorder |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Started menstruating | |

Other: (Surgery, serious injuries, chronic or recurring illness) _____

Current physical, mental, or psychological conditions requiring medication, treatment, special restrictions or consideration (continue on additional page, if necessary):

Please list all medications (both prescribed and over the counter) the camper/staff will be on while at camp:

****Medications must be in the original container and in enough quantity to last while at camp. ****

****Please notify us of camper/staff exposure to any communicable illnesses during the prior three weeks. ****

DIABETES INFORMATION:

How much daily exercise does your child get: 1-2 hours day 2-3 hours week 1-2 times month very rare

Does your child recognize when he/she has low blood glucose? Yes No

What are his/her signs?

Has your child had a seizure because of low blood glucose? Yes No Last occurrence _____

Has your child been in Diabetes Ketoacidosis (DKA)? Yes No Last occurrence _____

What insulin does your child use? _____

Is your child on a pump? Yes No Brand: _____

Is your child on a continuous glucose sensor? Yes No Brand: _____

Does your child use a MEAL PLAN or CARBOHYDRATE COUNTING? _____

Please give us an idea of the amount of food your child normally eats (either as total carbs or exchanges):

Breakfast: A.M. Snack: Lunch: P.M. Snack: Dinner: Bedtime snack:

	Medication:		For office use
1			<input type="checkbox"/>
2			<input type="checkbox"/>
3			<input type="checkbox"/>

Primary Health Care Provider: _____
 Address: _____ Phone: _____

Primary Diabetes Care Provider: _____
 Address: _____ Phone: _____

Mental Health Provider _____
 Address: _____ Phone: _____

Dentist _____
 Address: _____ Phone: _____

Has your child had any emotional difficulties for which professional help was sought? Yes No

Does your child tend to get homesick when sleeping away from home? Yes No

Does your child have chronic muscle, joint, or bone problems? Yes No

Does your child have ADD or ADHD? Yes No

If they are on medication during the school year, please continue their regular doses during their time at camp.

Does your child have any vision or hearing problems? Yes No

Is your child currently taking any medication for depression, anxiety, psychiatric, obsessive-compulsive, or mood disorders? Yes No

IMPORTANT – MUST BE COMPLETED FOR ATTENDANCE Parent/Guardian/Staff authorization. This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me and/or the examining health care provider.

I authorize The Barton Center for Diabetes Education, Inc. to release or receive all medical records, for the above-named camper/staff member, including but not limited to those records pertaining to substance abuse and emotional or mental health.

I hereby give permission to the health care provider selected by the Camp Physician to order X-rays, routine tests, and treatment for the health of my child/me, and in the event I cannot be reached in an emergency, I hereby give permission to the health care provider selected by the Camp Physician to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child/myself as named above.

Signature _____ Witness _____ Date _____
 Name of camper: _____

Name of Camper: _____

THIS PAGE TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER PRIOR TO CAMP

A physical examination must be completed within 24 months prior to camp.

****Please attach a copy of the immunization record including last tetanus injection.**

Date of examination: _____

Eyes _____ Glasses _____ Ears _____ Nose _____
Throat _____ Heart _____ Skin _____ Lungs _____
Posture (spine) _____ Hernia _____

ALLERGIES (FOOD, MEDICATION, ENVIRONMENT):

BP _____ Pulse _____ Weight _____ Height _____

The condition and resulting dietary and/or activity restriction or exemptions:

Current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions/considerations:

Current or ongoing medical treatment or medication:

Recent exposure and/or treatment of a communicable illness or disease:

DIABETES INFORMATION

Date of onset _____ Age at onset _____
most recent (A1C) _____

Insulin (brand, type):

Insulin pump (brand):

Continuous Glucose Monitor (brand):

History of frequent high or severe low blood sugars, recent treatment or hospitalization for diabetes related issues:

Please give dates of immunization for:					
Vaccine	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
Tetanus, Diptheria, Pertussis		_____	_____	_____	_____
Meningococcal		_____	_____	_____	_____
Hepatitis A		_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____
Polio		_____	_____	_____	_____
Measles, Mumps, Rubella		_____	_____	_____	_____
Varicella		_____	_____	_____	_____
Pneumococcal		_____	_____	_____	_____
Influenza		_____	_____	_____	_____

This person is capable of self-medication administration: Yes No

I have examined the person herein described and have reviewed the health history. It is my opinion that this person is physically able to engage in all camp activities with the exceptions noted above.

Signature of Licensed Health Care Provider (MD, NP, PA)

Date

Address

Phone

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Revised 11/25 ACA standards: HW-2, HW-5, HW-6, MA Health Department 430.150; 430.151; 430.152