The Barton Center for Diabetes Education, Inc.
PO Box 356, North Oxford, MA 01537
(508) 987-2056 www.bartoncenter.org

2017 HEALTH INFORMATION FORM – Campers, CITs, Staff, and Volunteers under 18 years of age

******This health form will be valid for one year. If any information changes during the course of this period, it is the applicant's responsibility to notify the Health Services Director.******

Last Name: _____ First Name: _____ Middle Initial: _____
Address: _____ City:_____ State:_____ Zip:_____
Date of Birth: _____ Age: _____ Gender: _____
*Staff only – Email:_____ * Staff only – Home phone: _____ Cell phone:_____

Primary Health Care Provider: _____
Mailing Address: _____ Phone: _____
Primary Diabetes Care Provider: _____
Mailing Address: _____ Phone: _____
Mental Health Provider _____
Mailing Address: _____ Phone: _____
Dentist: _____
Mailing Address: _____ Phone: _____

EMERGENCY CONTACT INFORMATION:

Parent/legal guardian (1): Name:_____ Relationship:_____
Address:_____ Home phone: _____
Cell phone:_____ Work phone:_____ Email:_____
Parent/legal guardian (2): Name:_____ Relationship:_____
Address:_____ Home phone:_____
Cell phone:_____ Work phone:_____ Email:_____

If a parent or guardian cannot be reached, please call:
Name:_____ Relationship_____ Phone Number:_____
OR Name:_____ Relationship:_____ Phone Number:_____

PLEASE PROVIDE COPIES OF FRONT AND BACK OF ALL INSURANCE AND PRESCRIPTION CARDS.

CURRENT HEALTH CONCERNS:

1. _____
2. _____
3. _____
4. _____

CURRENT MEDICATIONS (other than insulin): Please include vitamins, minerals, herbal and homeopathic remedies

	Medication	Dosage	Time
1.			
2.			
3.			
4.			
5.			
6.			

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Name:_____

ALLERGY		Reaction
Medication:	1.	
	2.	
	3.	
Environment	1.	
	2.	
Food:	1.	
	2.	

MEDICAL HISTORY:

Asthma	No	Yes	Heart disease	No	Yes
ADD/ADHD	No	Yes	Severe low blood sugar	No	Yes
Anxiety	No	Yes	Eating disorder	No	Yes
Depression	No	Yes	Learning or developmental disorder	No	Yes
Bedwetting	No	Yes	Problems sleeping	No	Yes
Constipation	No	Yes	Seizures	No	Yes
DKA	No	Yes	Other	No	Yes

If Yes, please describe:

_____

_____

Most recent A1C:_____ Date:_____

Please describe any concerns you have about your child's diabetes management:

_____

_____

SERIOUS INJURIES AND/OR ACCIDENTS

Type	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOSPITALIZATIONS (Medical, Surgical, Psychiatric)

Problem	Date
_____	_____
_____	_____
_____	_____

Do we have permission to speak with your child's mental health/diabetes/other health care providers? YES NO

I authorize The Barton Center for Diabetes Education, Inc. to release or receive all medical records, for the above-named individual, 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 on-site camp licensed medical provider to order X-rays, routine tests, and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the health care provider selected by the on-site camp licensed medical provider to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.

Parent/Guardian Signature: _____Date: _____