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

2018 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 Coordinator.******

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.			

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

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: ___________________