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

2019 Health Information Form – Campers, CITs, Staff, and Volunteers

******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: _____
Email:_____ 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—IF UNDER 18, MUST BE PARENT/LEGAL GUARDIAN:

(1): Name:_____ Relationship:_____
Address:_____ Home phone: _____
Cell phone:_____Work phone:_____ Email:_____
(2): Name:_____ Relationship:_____
Address:_____ Home phone:_____
Cell phone:_____ Work phone:_____ Email:_____
If under 18 and a parent/legal guardian cannot be reached, please call:
Name:_____ Relationship:_____ Phone number:_____
OR Name:_____ Relationship:_____ Phone number:_____

Diabetes Information: **I do not have diabetes: ☐**

Date of diabetes diagnosis: _____
Have you had a severe low blood sugar (seizure, loss of consciousness, or other) within the past 12 months? YES NO
Have you had a severe high blood sugar (hospitalization for DKA) within the past 12 months? YES NO
If yes, please describe event(s) including potential triggers and frequency:_____
_____

Brand and type of insulin used (please circle all that apply):
Rapid Acting: Humalog Novolog Apidra Fiasp
Short Acting: Regular (circle brand) – Humulin R Novolin R
Intermediate Acting NPH (circle brand) - Humulin N Novolin N
Long Acting: Glargine (Lantus) Detemir (Levemir) Degludec (Tresiba)
Other: _____
Do you use an insulin pump? YES NO If yes, date pump therapy was started: _____
Type of pump: _____ _____Infusion set:_____
Do you use a continuous glucose monitor? YES NO If yes, type of CGM:_____
Most recent A1C: _____ Date: _____

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Name:_____

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.			

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:

_____

_____

SERIOUS INJURIES AND/OR ACCIDENTS

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

HOSPITALIZATIONS (Medical, Surgical, Psychiatric)

Problem	Date
_____	_____
_____	_____
_____	_____

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Name:_____

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

UNDER AGE 18—PARENT/LEGAL GUARDIAN SIGNATURE REQUIRED
(For Campers/CITS/Staff/Volunteers under age 18)

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/Legal Guardian Signature: _____ Date: _____

AGE 18 AND OVER—STAFF/VOLUNTEER/CAMPER SIGNATURE REQUIRED
(For Staff/Volunteers/Campers age 18 and over)

I authorize The Barton Center for Diabetes Education, Inc. to release or receive all medical records, for me including but not limited to those records pertaining to substance abuse and emotional or mental health.

In the event I am incapacitated/unable to provide consent, I hereby give permission for the on-site camp licensed medical provider to order treatment and/or hospitalization to address my health condition, and in the event I am incapacitated/unable to provide consent, I hereby give permission to the health care provider selected by the on-site camp medical licensed provider to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me.

Staff/Volunteer/Camper Signature: _____Date: _____