2018 Medical Application

General Information Required for All Campers

PO Box 918 • Gainesville TX 76241
(940) 665-2011 • (940) 665-9467 fax
CampSweeney.org/medical

THIS BOX FOR OFFICE USE ONLY

CABIN: _____ PRE-REGISTERED BY: _____

EMERGENCY CONTACT #: _____ REGISTERED BY: _____

Camper's Last Name	Camper's First Name	Camper's MI

Date of Birth	Gender	Weight	Height	Blood Pressure

Diabetes Status: ☐ Type I Diabetes ☐ Type II Diabetes ☐ At risk of developing Diabetes ☐ Not Diabetic

MEDICAL CONDITIONS (other than Diabetes):

RECENT ILLNESSES that required treatment (please include treatment)

FOOD ALLERGIES, including Celiac/gluten? If yes, please list and include reaction

DRUG ALLERGIES, include reaction

May this camper participate in: Strenuous Activity? ☐ Yes ☐ No Swimming? ☐ Yes ☐ No Any Limitations? ☐ Yes ☐ No

MEDICATIONS (not insulin)

Prescriptions or over-the-counter medications must be brought in their original containers or will not be accepted. Need 20-day supply.

NAME	DOSAGE	FREQUENCY	DURATION

IMMUNIZATION RECORD

Obtain from primary care physician or from school records if not already on file with camp.

Diphtheria-Tetanus Date (no earlier than June 2010)	Polio Booster Date

MMR Dose 1 Date	MMR Dose 2 Date

Hep B Dose 1 Date	Hep B Dose 2 Date	Hep B Dose 3 Date

Camper's Last Name	Camper's First Name	Camper's MI

DIABETES INFORMATION

Date of Diagnosis	Most recent Check-Up Date	Most Recent Hemoglobin A1c DATE: VALUE:

INSULIN / MEAL PLAN Please indicate insulin ratios with Carbohydrate : Amount of Insulin (for example 10:1)

Please use the following Insulin Brand abbreviations when filling out dosages:

H Humalog
V Novolog
A Apidra
G Lantus
D Levemir
N Humulin N

	A.M.	NOON	SNACK	5 P.M.	BEDTIME
INSULIN DOSAGE					
SLIDING SCALE					
GRAMS OF CARB					

May we have permission to alter this camper's diet & insulin if camp activity necessitates? ☐ Yes ☐ No

PUMP INFORMATION Note: Campers who are using an insulin pump must bring enough pump supplies to last 20-day session.

Does camper use an insulin pump? ☐ Yes ☐ No If so, does camper plan to use the pump while at camp? ☐ Yes ☐ No

Pump Manufacturer	Pump Model

BASAL RATE. Please list rate as it appears on your pump.

Other Information

SEND COMPLETED FORMS TO:

MAIL:
CAMP SWEENEY
ATTN: Applications
PO Box 918
Gainesville TX 76241

FAX:
(940) 665-9467

This Medical Application:

- *Must be signed & dated no earlier than January 2, 2018, with appointment/medical information no earlier than January 2, 2018*
- *Should be received by our office* **two weeks prior to opening day**

Physician's Name (Please print)		Office Phone
Address		
City	State	Zip
REQUIRED Physician's Signature **X**		Date

Unsigned medical applications will not be accepted.

The Following to be completed by camp staff at Check-In on First Day of Camp:

Blood Sugar this morning: _____

Insulin dose taken: _____

For PUMP users

Last pump site change: _____

Frequency of pump site changes: _____