2019 Medical Application

General Information Required for All Campers

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

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

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

Date of Birth	Gender	Weight	Height	Blood Pressure

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 (how often)	DURATION (end date, if any)

IMMUNIZATION RECORD

Please enter dates MM/DD/YY below or submit copy of immunization record(s) separately. Obtain from primary care physician or from school records.

TdaP or DTaP Date (not earlier than June 2012)	Polio Booster Date	MMR Dose 1 Date	MMR Dose 2 Date
Haemophilus influenzae type B (HIB) Date	Hep B Dose 1 Date	Hep B Dose 2 Date	Hep B Dose 3 Date
Hep A Dose 1 Date	Hep A Dose 2 Date	Varicella or date camper had chicken pox	Meningococcal meningitis date (age 11+)

FOR OFFICE USE ONLY

Cabin: ☐ BO ☐ LE ☐ DI ☐ SI ☐ BR ☐ BY ☐ MO ☐ HI

Pre-Registered by/Date: _____/_____

Emergency Name/Phone: _____/_____

Registered by: _____

DIABETES INFORMATION ☐ Type I Diabetes ☐ Type II Diabetes ☐ Other Diabetes _____

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

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

INSULIN / MEAL PLAN

Please use the following Insulin Brand abbreviations when listing ratio dosages:
H – Humalog, V – Novolog, A – Apidra, G – Lantus, D – Levemir, J – Toujeo, T – Tresiba, S – Basaglar, F – Fiasp

What is your camper's insulin to carb ratio for the following? (Example, 1 unit of Novolog insulin for every 10 grams of carbs = 1V:10)

BREAKFAST _____ DINNER _____

LUNCH _____ BEDTIME _____

SNACK (15g carb) _____ Long Acting/Basal insulin: _____ Time administered: _____

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

CORRECTION SCALES

How much insulin do you give when correcting for highs during the following times? (Example, 1 unit for every 50 over 150)

BREAKFAST/MORNING _____ DINNER/EVENING _____

LUNCH/AFTERNOON _____ BEDTIME/OVERNIGHT _____

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 & Model: _____

BASAL RATE. List the time range followed by the rate of insulin delivery. Example: Midnight-3AM : 0.5 units/hr
ADD AN ADDITIONAL PAGE IF MORE THAN 4 BASAL RATES

Time range _____-_____ : _____ units/hr Time range _____-_____ : _____ units/hr

Time range _____-_____ : _____ units/hr Time range _____-_____ : _____ units/hr

CGM INFORMATION *Note: Campers who are using a CGM must bring their reader and enough CGM supplies to last 20-day session.*

Does camper use a CGM? ☐ Yes ☐ No If so, does camper plan to use the CGM while at camp? ☐ Yes ☐ No

CGM Manufacturer & Model: _____

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 01/02/2019, with appointment/medical information no earlier than 01/02/19*
- *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		Date
X		

Unsigned medical applications will not be accepted.

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

MORNING SUGAR/INSULIN	**PUMP USERS**	**CGM USERS**
Blood Sugar this AM: _____	Last pump site change: _____	Last CGM site change: _____
Insulin dose taken: _____	Frequency pump change: _____	Frequency CGM change: _____