



2021 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	Sex	Weight	Height	Blood Pressure	

PHYSICAL EXAM

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

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

MEDICATIONS (not insulin)

Prescriptions or over-the-counter medications must be brought in their original containers or will not be accepted. Need 19-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 2014)	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 Date or date camper had chicken pox	Meningococcal meningitis date (age 11+)
COVID-19 Diagnosis Date (if any)	COVID-19 Dose 1 Date (if any)	COVID-19 Dose 2 Date (if any)	COVID-19 Vaccine Brand <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Johnson & Johnson <input type="checkbox"/> AstraZeneca

PHYSICIAN SIGNATURE required at bottom of page 2

FOR OFFICE USE ONLY	
Cabin: <input type="checkbox"/> BO <input type="checkbox"/> LE <input type="checkbox"/> DI <input type="checkbox"/> SI <input type="checkbox"/> BR <input type="checkbox"/> BY <input type="checkbox"/> MO <input type="checkbox"/> 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	2020 HA1C DATE:	2020 HA1C VALUE:	2021 HA1C DATE:	2021 HA1C 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 19-day session.*

Does camper use an insulin pump? Yes No Is the camper on a looping system? 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 19-day session.*

Does camper use a CGM? Yes No

CGM Manufacturer & Model: _____

OTHER INFORMATION

SEND COMPLETED FORMS TO:

MAIL: FAX:
 CAMP SWEENEY (940) 665-9467
 ATTN: Applications
 PO Box 918
 Gainesville TX 76241

This Medical Application:

- Must be signed & dated no earlier than 01/02/2021, with appointment/medical information no earlier than 01/02/2021
- 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: _____