2024 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 2017)	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 Vaccine Brand ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ☐ AstraZeneca	COVID-19 Dose 1 Date (if any)	COVID-19 Dose 2 Date (if any)	COVID-19 Booster Date (if any)

PHYSICIAN SIGNATURE required at bottom of page 2

FOR OFFICE USE ONLY

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

Emergency Name/Phone: ______________________/________________________

Pre-Registered by/Date: ___________/___________

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	2022 HA1C DATE:	2022 HA1C VALUE:	2023 HA1C DATE:	2023 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:
CAMP SWEENEY
ATTN: Applications
PO Box 918
Gainesville TX 76241

FAX:
(940) 665-9467

Secure Email:
registrar@campsweeney.org

This Medical Application:

- *Must be signed & dated no earlier than 01/02/2024, with appointment/medical information no earlier than 01/02/2024*
- *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:		
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: __________