



SENSITIVE HEALTH INFORMATION - HANDLE APPROPRIATELY

Diabetes D.E.S.T.I.N.Y.

Diabetes Exercise Strategies Together In Network with You

Extreme Weekend For Children With Diabetes

- Health History Form -

Name: _____ Gender: _____ DOB: _____ Age at Diagnosis: _____

Date of most recent exam:	Height:	Weight:	Most Recent HbA1c:	and Date:
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HEALTH CONDITIONS OTHER THAN DIABETES

Please check, and indicate date if recent occurrence.

	Ear Infections		Dehydration/vomiting w/ ketones
	Heart defect/disease		Chicken pox
	Seizures		Insect sting allergy
	Bleeding/clotting disorders		Penicillin allergy
	High blood pressure BP: (most recent)		Other drug allergies:
	Psychological counseling		Poison Ivy
	Asthma		Other allergies:
	Celiac		Other:

INSULIN

Please indicate all types of insulin currently used:

- Humalog Novolog Apidra Regular
 NPH Lantus Levemir Other: _____

LONG ACTING INSULIN

Dosing of Long-Acting Insulin (specify type and dose):

AM _____
 PM _____
 Bedtime _____

Camper's Name: _____
 (include on each page)



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RAPID ACTING INSULIN

Standard dose: Lunch Dinner Other
Insulin to Carb Ratio (if applicable): Breakfast: Lunch: Dinner: Bed:

Correction or Sliding Scale: _____ units for every _____ more than _____ mg/dl.
Other:

Blood glucose _____ to _____, give _____ units
Blood glucose _____ to _____, give _____ units
Blood glucose _____ to _____, give _____ units
Blood glucose _____ to _____, give _____ units
Blood glucose _____ to _____, give _____ units

Injection sites (Please indicate if camper has lipohypertrophy):

Abdomen Arms Legs Buttocks Other: _____

Insulin Pump: YES NO

If YES, Brand/Model of Pump: _____

Infusion sets: _____

Camper's Name: _____
(include on each page)



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Recommendations and Restrictions while at camp:

Treatment other than diabetes to be continued at camp:

Required medications (other than insulin) to be administered while at camp (including name/dose/frequency):

Additional health concerns/information:

This patient is physically and emotionally able to participate in an active camp program:

YES NO

NOTE: Each Camper will be monitored frequently and insulin dosing/plan will be altered to provide the safest environment possible during the camping experience. Changes made will be reviewed with the family at the end of camp and recommendations will be provided.

HEALTH PROVIDER CONTACT INFORMATION

Name
Address
Phone
Physician/NP/PA's Signature and Date:

Camper's Name: _____
(include on each page)