CAMPER MEDICAL INFORMATION FORM

GENERAL:

Name _____
Birth date _____
Parent/Guardian Phone _____ Alternative Emergency Phone_____

How long has the camper had diabetes? _____

How often does the camper have hypoglycemia? _____times per Day
_____times per Week
_____times per Month
_____Never or less than once per month

Have they had a seizure from low blood sugar *in the last year*? [ ] Yes [ ] No

Which of the following symptoms do they reliably experience with low blood sugar? **Mark all that apply**
[ ] Shaking (not seizure) [ ] Sweating [ ] Nervous [ ] Hungry [ ] Tummy ache
[ ] Fast heart beat [ ] more emotional
[ ] Abnormal behavior (violence/wandering/staring/etc.)
[ ] Other (specify) _____
[ ] No noticeable symptoms until Unconscious or having a Seizure

DIETARY:

Meals at Camp Hickory Hill are served in a serving line/cafeteria style with staff measuring carbohydrate servings. Campers are asked, with staff assistance to select items from the posted menu prior to the meal. Although we will respect pre-existing carb limitations, they are only required for campers using 70/30, other pre-mixed insulin or fixed doses of insulin per meal. Most Campers are not expected to be following a fixed meal plan.

If the camper will be following a fixed carbohydrate meal plan at camp please complete the following. If the camper does not eat at one of the specific times please put a zero in the blank. If the camper will be counting carbohydrate and dosing insulin accordingly (applies to most campers) please leave blank.

FIXED MEAL PLAN:
One "carb choice" is the same as 15 grams of carbohydrate. Please divide if necessary to get carb choices and please round to the nearest half carb choice.

Breakfast____Carb choices Morn snack____Carb choices

Lunch____Carb choices Afternoon snack ____Carb choices

Supper____Carb choices Bedtime Snack____Carb choices

Mark any of the following only if they apply to the camper:

[ ] Celiac disease

[ ] Other significant dietary restrictions/allergies

Explain_____

[ ] Vegetarian or avoids certain foods on moral or religious grounds

Explain_____

[ ] Active eating disorder including anorexia or bulimia

[ ] Poor eater or slow eater or picky eater

INSULIN:

If the camper will be using an insulin pump during camp complete Section A
If the camper will be using Lantus or Levimir during camp complete Section B
If the camper will be using 70/30, other pre-mixed, or a custom insulin plan during camp complete Section C
If the camper will be using only oral medications (camper with type 2 diabetes), skip these sections and include diabetes medications under other medications.

COMPLETE ONLY ONE SECTION.

SECTION A

Pumping insulin

Infusion sites often do not last as long at camp as at home. Please try to bring an adequate supply of infusion sets, skin prep aids, inserter devices and reservoirs to camp with a small bag/box/tote to keep supplies in. All campers who are pumping will be issued a cubby slot in the medical area to keep necessary materials. We will supply all insulin.

We encourage campers to understand and operate their own pumps. However, campers will be expected to verify with a counselor or medical staff prior to delivering a bolus. Knowledgeable individuals are available at all meal and snack times to assist campers with their pumps. We understand that settings may change prior to camp, please enter current settings below. Medical staff will verify and update at check-in.

Pump make and model_____

Preferred infusion set_____

Preferred insulin_____

Code to activate (if applicable) _____

Does the camper know how to deliver a bolus using pump settings (not just quick boluses)? [ ] YES [ ] NO

Does the camper insert their own infusion sites? [ ] YES [ ] NO

All pumps have Basal and Bolus settings, though the name/location may vary, please consult your manual or health care provider if necessary to complete the following.

Please fill in the following table regarding basal inulin:

Start Time (am/pm or 24hr times please)	Rate in Units per Hour

Please fill in the following table regarding bolus insulin:

⚠ If the camper does not use their bolus settings or does not have bolus settings mark here [ ] and leave the table blank.

Is the pump set for [ ] carbs/grams (most common)
[ ] exchanges/exch

Start Time (am/pm or 24hr times please)	Ratio (I:C or carb ratio

⚠ Please fill in all sections that you can find within the pump menus. If you and the camper can't find <u>any</u> of the pump settings even after consulting the manual please mark here [ ] and leave the rest of the section blank. Please do not guess or use old paper work.

The following settings exist in different menus on different pumps and may not all be present on any particular pump. Please complete as best you can for your pump.

Insulin action time _____
Target range/goal _____ to _____ mg/dL
Minimum blood sugar for calculations (Omnipod only) _____mg/dL
Threshold suspend (Medtronic 530G only) _____mg/dL
Max Bolus _____ units (the setting in the pump not what you personally believe/do)
Max Basal rate_____ units/hour (the setting in the pump not what you personally believe/do)
Sensitivity/correction factor _____

SECTION B

Campers completing this section are expected to be using a long acting basal insulin and short acting mealtime insulin. Short acting insulin is administered at all meal and snack times as well as needed for high blood sugar. Long acting basal insulin will only be administered in the morning and/or late evening. Insulin doses may be changed during camp at the discretion of the medical director.

[ ] mark if using pens for basal/long acting insulin
[ ] mark if using pens for bolus/mealtime insulin
[ ] mark only if using a pen that requires cartridges (ie. Novopen jr, memoir, luxura, etc.)
Which pen: _____
[ ] mark if camper can't give their own injections

BASAL/LONG ACTING:
Preferred long acting basal insulin:
[ ] Lantus _____Units in the morning _____Units in the evening
[ ] Levimir _____Units in the morning _____Units in the evening

BOLUS/SHORT ACTING
Preferred short acting/mealtime insulin
[ ] Humalog [ ] Novolog [ ] Apidra

⚠ Fixed doses of insulin at meals require the completion of a meal plan above. If camper takes a fixed dose of insulin with meals attach a list of doses by meal/snack. Most campers use insulin to carbohydrate ratios.

Please complete the following table for insulin to carbohydrate ratios to be used during camp. If the camper has a single ratio to be used at all times you need only enter it on the top line, otherwise make an entry for all lines, even if there is duplication. Please convert all carbohydrate to grams, 1 carbohydrate choice/exchange is 15grams. The top line is an example of what a 1:15 (1 unit for every 15 grams carbohydrate eaten) should look like.

Meal/Snack	Ratio units in first column grams in second	
Example only	1	15
Breakfast		
Morning Snack		
Lunch		
Afternoon snack		
Supper		
Night snack		

Please complete the following table for the correction factor to be used at camp. A correction factor is sometimes called sliding scale, if you only have a sliding scale please copy it and attach to this form. Some campers will have a single ratio to use at every meal. If the camper has a single correction factor to be used at all times you need only enter it on the top line, otherwise make an entry for all lines, even if there is duplication.

The example shows how to complete for a correction of 1 unit every 50 that the blood sugar is over 150 Or 1 unit will lower the camper's blood sugar 50 mg/dL and the goal is 150mg/dL following the meal
Or if the camper's blood sugar is between 150 and 200 they will receive one extra unit of insulin in addition to their food bolus.

⚠ Correction insulin at other than mealtimes will be only at the discretion of the medical staff and is not considered routine.

Meal	Units	Amount of decline expected	Target
Example Only	1	50	150
Breakfast			
Lunch			
Supper			

SECTION C

Campers completing this section will have no entries in sections A or B.

[ ] University of Missouri "step plan" with 70/30 (NPH/Regular) [Novolin or Humulin brand] "two shot" regimen (includes some Springfield patients.)

[ ] Using Whole steps (increase or decrease 2 unit at breakfast and 1 unit with supper with each change)
[ ] Using Half steps (increase or decrease 1 unit at breakfast and ½ unit with supper with each change)
Please enter the current doses. Medical staff will review and update as necessary at check-in.
_____Units before breakfast_____Units before supper

[ ] Other pre-mixed insulin plan

[ ] 70/30 NPH/Regular ____units Breakfast ____units Supper
[ ] Nova*log* mix 70/30 ____units Breakfast ____units Lunch ____units Supper
[ ] Humalog mix 75/25 ____units Breakfast ____units Lunch ____units Supper
[ ] Humalog mix 50/50 ____units Breakfast ____units Lunch ____units Supper

[ ] Other Plan: Please describe, in writing on another sheet and attach. Included insulins used, how prepared if custom mixed or diluted, and amount/timing of doses.

OTHER MEDICAL:

Please list other medical conditions, including those related to mental health, such as depression or anxiety, which the camper has? _____

_____

_____

Using the following table, please list all medications. Medications are dispensed prior to meals and at bedtime. Please enter the dose under the appropriate column. Timing exceptions will be made only if medically necessary. Please bring adequate supplies of all medicines other than insulin, to camp. You will be asked to prepare a pill box for all scheduled oral medications at check-in. For "as needed" and non-oral medications we will store them in the medical area and dispense as indicated. If you would like to prepare a pill box ahead of time, please use a standard commercial pill box with the correct number of compartments, and clearly label with campers name and administration times if not clear on the compartments. Please bring the original bottle with you in case we need to verify any medications. Fill out the following table even if you are bringing your own pill box. For prescription medications used only "as needed", like some migraine medications, write PRN next to the reason for taking and leave the dose columns blank. We stock a wide variety of non-prescription medications for use by the medical staff as needed for minor conditions. **With the exception of birth control pills in their original packaging, campers are not to have in their possession or consume any medication at any time unless authorized by medical staff.** Birth control pills should still be listed below even if left with the camper. Medical staff will not be responsible for monitoring birth control administration unless the package is given to medical staff at the time of check-in.

Medication Name	Strength (ie. 50mg tablet)	Route (ie. By mouth, on skin, etc.)	Reason taking (ie. Blood pressure, ADHD, etc.)	Dose BFast (ie. 1 tablet)	Dose Lunch	Dose Supper	Dose bedtime

List Medication allergies:

Medication Name	What is the Reaction?

List Food allergies:

Food	What is the Reaction

Has the camper had any recent hospitalizations or surgeries? ( ) Yes ( ) No

If yes, explain (date(s) and reason(s)):_____

_____

_____

_____

_____

Most recent Hemoglobin A1c (HbA1c):_____% on / / 2015

Date of last TETANUS shot? ___/____/____

Will the camper be up to date on their immunizations at the start of camp? ( ) Yes ( ) No

The Campers Primary Physician:_____Phone _____
Address_____

The Campers Diabetes Physician:_____Phone_____
Address _____

The Campers usual Pharmacy:_____Phone_____

PARENT/GUARDIAN SIGNATURE _____DATE_____

MEDICAL CONSENT

I/we, the parent or guardian of _____, hereby request and authorize the camp Medical
(Campers Name)
Director, Michael Gardner MD, and/or his designees to administer prescribed medications and to provide routine health care, including diagnosis and treatment of medical conditions, as deemed necessary by the camp Medical Director, to my child while attending Camp Hickory Hill. In the event of illness or injury, I authorize the camp Medical Director and/or his designees to act for me in obtaining urgent or emergent medical and/or surgical treatment and/or hospitalization for my child.

It is further understood that every reasonable effort will be made to contact me as promptly as possible when a problem concerning my camper is considered to be a medical emergency.

In the event I/we cannot be reached please contact:

Name: _____Phone: _____

Parent(s) or Guardian Signature _____Date_____
_____Date_____

Phone number (home/cell) _____

(work) _____

Address _____

Date signed _____

INSURANCE INFORMATION

Name of Insured: _____

Name of Insurance Company: _____

Policy and/or Group Number(s): _____

PLEASE ATTACH A COPY OF THE CAMPERS INSURANCE CARD.
PLEASE MAKE SURE YOU HAVE ENTERED ALL REQUESTED INFORMATION AND SIGNED AND DATED THIS FORM BEFORE MAILING IT TO US. OTHERWISE, THE APPLICATION MAY BE RETURNED.
You may return this form by Fax, US mail or send a scanned copy via e-mail. Please be advised that in general e-mail is not a secure method for transmission of confidential information and is not legally protected by laws covering US mail or phone lines (including Fax).

PHYSICAL EXAMINATION

Provider: Please complete the following. Please feel free to attach copies of medical records if it is more efficient (i.e. problem list or medications). Please initial or sign any documents attached and complete the final attestation and sign at the bottom of this form.

Name _____Birth date _____

Weight_____Height _____Temperature _____BP ___/___HR _____

Constitutional: Normal or describe_____

Eye: Normal or describe_____

HENT: Normal or describe_____

Neck: Normal or describe_____

Cardiovascular: Normal or describe_____

Respiratory: Normal or describe_____

Abdominal: Normal or describe_____

GU: Normal or describe_____

Skin: Normal or describe_____

Musculoskeletal: Normal or describe_____

Neurological: Normal or describe_____

Psychiatric: Normal or describe_____

Other findings: Normal or describe_____

Are any of the paired organs known to be absent? YES NO

Medication Allergies:_____

Medications_____

_____

Active diagnoses/problem list_____

_____

In my opinion, the above-named person is capable of participating in a physically vigorous overnight summer camp program with the following exceptions (State none if no exceptions):

_____

_____

_____

Signature _____, M.D./D.O./FNP Date _____

Address: _____Phone: _____

_____