

2010 - GALES CREEK CAMP DIABETES HEALTH HISTORY

Camper: _____ Date of Diagnosis: _____

Parents/Guardian(s): _____

Address: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Emergency Contact: friend/relative (different from those listed above). **INCLUDE AREA CODE!!!**

Name	Daytime Phone Number	Evening Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Diabetes Physician Name: _____

Physician's Address: _____ Zip Code: _____

Physician's Office and Emergency Phone Numbers: _____

INSULIN INJECTIONS:

Insulin brand: Lilly Novo Nordisk Aventis

Kind of insulin: (check all that apply) Humalog NovoLog Regular NPH Lantus

Levemir Apidra

Who draws/gives insulin injections at home? camper mom dad other

What sites are used? abdomen arms thighs buttocks

Any problems with injection sites (lumps or dents)? _____

Syringe size: 30-unit 50-unit 100-unit Needle size: 1/2 inch 5/16 inch (sht)

Insulin Pen: Novo Pen Novo pen Jr. Flex pen Lilly Pen Solostar Pen Kwik Pen

Pen Needle size: 3/16 inch 1/4 inch 5/16 inch 1/3 inch 1/2 inch

Pumpers: **Must bring all of your own pump supplies – we will provide insulin only**

Pump: Paradigm, specific type: _____ Animas, specific type: _____

Cozmo Spirit Omnipod

Is camper able to program pump? (basal rates, bolus ratios etc.) yes yes but, help needed no

Is camper able to change do set changes? yes yes, but, help needed no

Do you wear a sensor No Yes If yes, please specify _____

HYPOGLYCEMIA (LOW BLOOD SUGAR):

Usual signs or symptoms: _____

Frequency of low blood sugar (per week): _____

Pattern or time of day: _____

Treatment used at home: _____

Does your child know he/she is having a low blood sugar? yes No

Has child needed glucagon within last year? no yes, when _____

Other problems associated with low blood sugar: _____

HYPERGLYCEMIA (HIGH BLOOD SUGAR):

Ketoacidosis (DKA) Last episode: _____

BLOOD GLUCOSE MONITORING:

Glucose meter used at home (specify type): _____

Frequency/times per day (circle one): 0 1 2 3 4 5 6+

Does child do his/her own testing? yes no If no, who assists? _____

Problems associated with blood glucose monitoring: _____

Last hemoglobin A₁C results: _____ Date: _____

MEAL PLANNING/ACTIVITY: Does child follow a meal plan at home? yes no

If yes, Carb counting: Specify Plan: _____

other: specify: _____

Meal/snack times: B _____ Snack _____ L _____ Snack _____ D _____ Snack _____

Special dietary requirements: Please specify (i.e. vegetarian, lactose intolerant, gluten free etc.) _____

Food Allergies: _____

Food dislikes: _____

Milk: non-fat 1% 2% whole

How much activity/exercise does your child get on a regular basis? (scale of 1 to 10, 10 being most active): _____

OTHER:

Other medical problems (be specific): _____

Other medications specify name/dose/frequency: _____

History of bedwetting? yes no

If yes, treatment for bedwetting at home: _____

Will family provide Pull-Ups or disposable underpants for use at camp? yes no

Other special needs or considerations: _____

EDUCATION:

Education needs and goals of camper: _____

CONSENT FOR TREATMENT

I, _____ give permission to physicians, nurses and staff at Gales Creek Camp to provide necessary medical care, including but not limited to insulin and meal plan adjustments as needed.

Signature of Parent/Guardian

Date

THIS FORM MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN