2023 PRE-CAMP MEDICAL INFORMATION

Please fill out this form **prior to coming to check-in**. Ensure the information from the day before camp and the morning of the first day of camp is complete. ***Parents are responsible for and must stay until the bus arrives!***

Name:	DOB:	Gender:	Age:	Diagnosis Age:
Current Diabetes Provider:	Last A1c:	Last A1c Date:	Height (inches):	Weight (lbs):
Name of Parent/Guardian that can be reached **tonight:**		Parent/ Guardian Cell phone:		

Do you have any *medication* allergies? [ ] No [ ] Yes	If yes, please list:		
Do you have any *food* allergies or restrictions? [ ] No [ ] Yes	If yes, please list:		
Medical diagnosis other than diabetes? [ ] No [ ] Yes	If yes, please describe:		
What other medications do you take (other than insulin)? ***Each medication must be in an original labeled prescription bottle, or over-the-counter bottle, if non-prescription***.	**Medication**	**Dose**	**When Taken (Time/s of Day)**

Have you been to camp before? [ ] No [ ] Yes	If yes, please describe any specific things we should know : *(e.g seizure, sensitive to insulin @ camp)*			
Have you made any changes to your insulin dosing in preparation for camp? [ ] No [ ] Yes	Please describe what changes were made:			
Is snack times Required or Optional? Is it covered by insulin? (Yes or No)	*Example* ***Required-Yes***	**Morning**	**Afternoon**	**Evening**

Name: **DOB:**

Insulin Pump ***if applicable*** Make and Model: Serial Number:	Last Pump Site Change (Date and Time):	Sensor ***if applicable*** Name: Type (CGM?):	Last Sensor Change (Date and Time):
Name of Short Acting Insulin (Bolus):	Name of Long Acting Insulin (Basal): ***if applicable***		Admin Time of Basal Insulin:

Complete if <u>NOT</u> using an insulin pump. (if using an insulin pump, complete the next table):

	Example	**Breakfast**	**Lunch**	**Dinner**	**Bedtime**
Insulin to carbohydrate ratio? **Carb Ratio**	***1:15*** **means 1 unit covers 15 grams of carbs*				
Correction insulin dose for hyperglycemia? **Correction Factor**	***1:50*** **means 1 unit lowers BG by about 50 mg/dL*				

Complete if using an insulin pump:

Time	**Basal Rates**	**Carb Ratio**	**Correction Factor**	**Target Range**
Example	**0.5** **means the pump delivers 0.5 units/hour*	***1:15*** **means 1 unit covers 15 grams of carbs*	***1:50*** **means 1 unit lowers BG by about 50 mg/dL*	**120-150** **means the number the pump is set up to correct*
12:00 MN				

Pre-camp information

		Breakfast	**Lunch**	**Dinner**	**Bedtime**	**Notes**
EXAMPLE	***Pre-meal BG***	155	220	104	135	*Dance recital after lunch*
	Carbs	15	30	60	0	
	Insulin Given	2	6	4	0	
One Day <u>before</u> Camp	***Pre-meal BG***					
	Carbs					
	Insulin Given					
Day of Camp	***Pre-meal BG***					
	Carbs					
	Insulin Given					

HEALTH SCREENING FORM

Name: (Last, First, MI)	DOB:	Gender:	Arrival Date:	Departure Date:
[ ] Camper [ ] Staff [ ] Others :			**CAMP: Camp Conrad Chinnock**	

PARENT: Complete Sections 1 and 2 ONLY

SECTION 1

No	Yes	Health History
☐	☐	Has your Child been diagnosed with COVID-19 in the past 10 days?

If yes, please explain: _____

_____

SECTION 2

No	Yes	Has your child shown any of, or been in contact with others who exhibited, the following symptoms within the past 24 to 48 hours prior to camp arrival?
☐	☐	Fever (Oral temperature 99.9°F or above))
☐	☐	Sore throat, cough, congestion, or runny nose
☐	☐	Vomiting, Diarrhea, or digestive problems
☐	☐	Loss of taste or smell
☐	☐	Severe itching of body or scalp, rash
☐	☐	Open draining sore on skin
☐	☐	Severe headache
☐	☐	Flu or flu like symptoms (fever, sore throat, cough, weakness, fatigue, sneezing, nausea, body aches)
☐	☐	In close physical contact with anyone who has tested positive for COVID-19 in the past 10 days.

SECTION 3 (do NOT complete)

No	Yes	Result of the health screening:
☐	☐	Attended camp
☐	☐	Quarantined at camp in the isolation area
☐	☐	Sent home/did not attend camp
☐	☐	Has a copy of the staff/camper immunization record been obtained?

_____ _____

Signature of Health Supervisor Date Reviewed