

# CAMP POSSIBILITIES HEALTH HISTORY FORM

This form may be completed by the parent/guardian in conjunction with a licensed medical professional. However, **signatures from both a parent/guardian and licensed medical professional are required.**

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

Child's Diabetes Care Provider \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

Child's Primary Care Provider \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

I have examined the camper on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date must be within 6 months of camp)

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_/\_\_\_\_

Most Recent Hemoglobin A1c Measurement \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Month/Year Diabetes Diagnosed \_\_\_\_/\_\_\_\_ Age at Diabetes Diagnosis \_\_\_\_\_

History of ketoacidosis in year prior to camp? \_\_\_Yes \_\_\_No

If yes, number of episodes and reasons \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

History of severe hypoglycemia requiring emergency department visit or hospital admission in the year prior to camp? \_\_\_Yes \_\_\_No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

History of hypoglycemia unawareness? \_\_\_Yes \_\_\_No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Insulin Delivery** \_\_\_Injections \_\_\_Pump \_\_\_Other, specify\_\_\_\_\_

**Continuous Glucose Monitor (CGM)** \_\_\_Yes \_\_\_No

If yes, please specify \_\_\_Dexcom G6 \_\_\_Dexcom G7 \_\_\_Freestyle Libre 2 \_\_\_Freestyle Libre 3 \_\_\_Guardian \_\_\_Eversense

**INSULIN PUMP USERS ONLY (Type of Insulin Pump)**

\_\_\_MiniMed 770G \_\_\_MiniMed 630G \_\_\_MiniMed 780G

\_\_\_Omnipod EROS/Classic \_\_\_Omnipod DASH \_\_\_Omnipod 5

\_\_\_T-slim with Basal IQ \_\_\_T-slim with Control IQ \_\_\_Mobi

\_\_\_iLet® Bionic Pancreas System

Does the camper use a loop insulin delivery system, such as Tidepool? \_\_\_Yes \_\_\_No

**Injection or Pump Insertion Sites** \_\_\_Abdomen \_\_\_Arms \_\_\_Legs \_\_\_Buttocks \_\_\_Other: \_\_\_\_\_

\_\_\_\_\_ Does camper have lipohypertrophy, and if so, at what sites?

**Insulin Type(s) (Check all that apply)**

Rapid-Acting Insulin \_\_\_Humalog \_\_\_Novolog \_\_\_Apidra \_\_\_Admelog \_\_\_Regular \_\_\_Other: \_\_\_

Long-Acting Insulin \_\_\_Lantus \_\_\_Basaglar \_\_\_Toujeo \_\_\_Levemir \_\_\_Tresiba \_\_\_NPH \_\_\_Other

Premixed Insulin (specify brand): \_\_\_\_\_70/30 \_\_\_\_\_50/50 Other: \_\_\_\_\_

**INSULIN PUMP USERS ONLY**

<u>Basal Rate(s)</u>		<u>Meal Bolus I:C Ratios</u>		<u>Correction Factor(s)</u>		<u>Target Goal(s)</u>	
<u>Time</u>	<u>Units/hour</u>	<u>Time</u>	<u>Ratio</u>	<u>Time</u>	<u>CF/ISF</u>	<u>Time</u>	<u>Goal</u>
12:00 AM		12:00 AM		12:00 AM		12:00 AM	

**INJECTION USERS ONLY**

**Correction Factor** \_\_\_\_\_ unit(s) for every \_\_\_\_\_ more than \_\_\_\_\_ mg/dL

Subtract \_\_\_\_\_ units for every blood glucose less than \_\_\_\_\_ mg/dL

**Insulin to Carbohydrate Ratios (for campers using I:C ratios)**

Breakfast \_\_\_\_\_:\_\_\_\_\_ Lunch \_\_\_\_\_:\_\_\_\_\_ Dinner \_\_\_\_\_:\_\_\_\_\_ Bedtime \_\_\_\_\_:\_\_\_\_\_

**FIXED INSULIN AND/OR CARBOHYDRATE REGIMEN USERS ONLY**

	Units of Rapid-Acting Insulin	Units of Long-Acting Insulin	Units of Pre-Mixed Insulin (70/30, 50/50)	Carbohydrates Per Meal
Breakfast				
Lunch				
Dinner				
Bedtime				

Meal Plan \_\_\_None \_\_\_ADA Calories \_\_\_Carbohydrate Counting

Special Dietary Considerations \_\_\_\_\_

Allergies (medications, foods, environmental) \_\_\_\_\_

Other Medications Taken Regularly (prescribed and over-the-counter) \_\_\_\_\_

Please provide and describe information on **ALL** current and ongoing treatment, medical conditions, psychological conditions, behavioral conditions, physical conditions, dietary restrictions, special needs, special restrictions and considerations that camp needs to be aware of to ensure your child has a positive experience at camp \_\_\_\_\_

Detailed recommendations, restrictions, and treatment other than for diabetes to be continued at camp \_\_\_\_\_

Are there any camp activities from which the child should be exempted for health reasons? \_\_\_\_\_

_____	_____	____/____/____
<b>Parent/Guardian Name (print)</b>	<b>Parent/Guardian Signature</b>	<b>Date</b>
<b>Licensed Medical Personnel (please complete)</b>		
Full Name and Title (please print) _____		
Address _____		
Phone _____	Date Form Completed ____/____/____	
Signature _____		