



**SENSITIVE HEALTH INFORMATION-HANDLE APPROPRIATELY**

Diabetes D.E.S.T.I.N.Y.<sup>[1]</sup><sub>[SEP]</sub>  
 Diabetes Exercise Strategies Together In Network with You  
 Extreme Weekend For Children With Diabetes<sup>[1]</sup><sub>[SEP]</sub>

**Health History Form** –Due within 2 weeks of registration

To be filled out by parent/guardian and reviewed & signed by Health Care Provider

Name	Gender	Birthdate	Age at camp	Age at Diagnosis
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Last exam date:	Height	Weight	Blood pressure	Hemoglobin A1C and date:
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Drug Allergies:	Food Allergies:	Other Allergies (ie. Latex, bee stings, Environmental, etc.)	Are all vaccinations up to date? (Please attach a copy of vaccine record)
		Do they carry an EpiPen? Yes No	Yes No

Please list all major and minor health conditions:

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

Please CIRCLE all types of insulin currently used:

Humalog Novolog Admelog Apidra NPH Lantus Levemir Tresiba Toujeo Other:\_\_\_\_\_

Please CHECK insulin delivery method and write name of device

\_\_\_ Insulin pump \_\_\_\_\_ Infusion set name \_\_\_\_\_  
 \_\_\_ Insulin pen/cartridge \_\_\_\_\_ or \_\_\_ Insulin disposable pen \_\_\_\_\_  
 \_\_\_ Syringe & vial \_\_\_\_\_

Please CIRCLE injection/pump sites (and indicate if camper has lipohypertrophy)

Arms            Stomach            Legs            Buttocks            Other:\_\_\_\_\_

**HEALTH PROVIDER CONTACT INFORMATION**

Name:
Signature of MD/NP/PA and date:

Name \_\_\_\_\_ DOB \_\_\_\_\_

**Insulin Doses**

Time or meal	Insulin to Carb ratio	ISF/CF	Target	Time:	Basal rate units/
				24 hr total:	

**Long acting insulin name, dose and time:** \_\_\_\_\_

How does camper usually adjust insulin dose or carbohydrate intake to prepare for exercise/activity?

Does camper have history of hypoglycemia unawareness? YES \_\_\_\_\_ NO \_\_\_\_\_

What are camper's symptoms with hypoglycemia?:

Please list camper history of severe hypoglycemia (LOC, seizure) requiring Glucagon, paramedic support, ER visit or hospitalization admission?

Will camper wear CGM at camp? YES \_\_\_\_\_ NO \_\_\_\_\_

Please list history of any DKA episodes:

Is the camper currently in treatment by a counselor/psychologist/psychiatrist? NO \_\_\_\_\_

If YES, please list most recent visit:

Are there any behavioral/psychological concerns of which you want us to be aware of?

**Additional Recommendations and Restrictions while at camp:**

**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.**

**This patient is physically and emotionally able to participate in an active camp program: YES \_\_\_\_\_ NO \_\_\_\_\_**

**HEALTH PROVIDER CONTACT INFORMATION**

Name:
Signature of MD/NP/PA and date:

SCAN AND EMAIL YOUR HEALTH HISTORY FORM and immunization record TO: [medteam@diabetesdestiny.com](mailto:medteam@diabetesdestiny.com)

FROM:

**HEALTH PROVIDER INFORMATION**

Name:
Name and Address of Medical Center:
Phone Number and Fax Number

HEALTH HISTORY FORMS MUST BE RECEIVED TWO WEEKS AFTER REGISTRATION OR THE CAMPER'S SLOT MAY BE GIVEN TO ANOTHER CAMPER IF WE ARE OVERSOLD.

Instructions to Parent/Guardian:

- 1) Please fill out the Health History forms (2 pages)
- 2) Submit to your Health Care Provider to review, sign & return via email.
- 3) If the forms cannot be emailed, contact us for other options:

**John Boyer**

**Director**

**Diabetes DESTINY**

**410-858-8646**

Instructions to Health Care Provider:

- 1) Please review and sign the Health History forms.
- 2) Use this page as a coversheet and email the completed forms to: [medteam@diabetesdestiny.com](mailto:medteam@diabetesdestiny.com)
- 3) Please return original copies to parents for their keeping.
- 4) If forms are unable to be emailed, please have parent EMAIL to the listed address above. Thank you!

**HEALTH PROVIDER CONTACT INFORMATION**

Name:
Signature of MD/NP/PA and date: