**Health Information Form for Children**

**Diabetes and You: Kamp for Kids**

**Mail Completed Form to:**

Kamp4Kids

University of Delaware School of Nursing

25 North College Avenue, McDowell Hall 386

Newark, DE 19716

Name: Birthdate: Sex: □Female □Male

Grade Completed: Age of Child at time of Kamp:

Grade Entering (in the upcoming fall):

Name of Parents/Legal Guardian:

Email Address:

Home Phone: Business Phone: Cell Phone:

Child has diabetes: □YES □NO If Yes, Date Diagnosed:

If NO, Name of Sibling/Friend of Child with Diabetes:

Name of Sibling/Friend(s) you would like to be paired with: Age:

Age:

**In case of emergency, if parents/guardians cannot be reached, please notify:**

1. Name, Address, Phone

2.Name, Address, Phone

**Medical Release Information:**

Name of Health Insurance Provider:

Policy ID# : Policy Group#:

Family Physician:

Hospital Preference:

**Health History**

(Check with X & give approximate dates)

□ Asthma \_\_\_\_\_\_\_\_\_\_\_

□ Frequent ear infections\_\_\_\_\_\_\_\_

□ Heart disease/defect \_\_\_\_\_\_\_\_\_\_\_ □ Chicken pox\_\_\_\_\_\_\_\_\_\_\_\_

□ Convulsions\_\_\_\_\_\_\_\_\_\_\_ □ Measles\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Diabetes\_\_\_\_\_\_\_\_\_ □ German measles \_\_\_\_\_\_\_\_\_

□ Bleeding/clotting disorder\_\_\_\_\_\_\_\_ □ Mumps \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Hypertension\_\_\_\_\_\_\_\_ □ Mononucleosis\_\_\_\_\_\_\_\_\_\_\_

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are all immunizations up-to-date? **□ Yes □ No**

Date of last tetanus (DPT, DT, TT) shot:

***If your child has diabetes, is it well controlled?*  □ Yes □ No**

If **No**, please describe:

***If your child has diabetes, what is his/her HgbA1c?***

***Does your child have any activity limitations?***   **□ Yes □ No**

If so, what are they?

***Does your child require a specific snack before activity?***  **□ Yes □ No**

If so, what?

***Does your child have any dietary restriction*? □ Yes □ No**

***Does your child have any food allergies?* □ Yes □ No**

If so, what are they?

***Does your child have a calorie restriction?* □ Yes □ No**

If so, what?

***Does your child have any of the following allergies?*** [Medications (list),animals, seasona/environmental, insect stings, plants (poison ivy, etc), food, other] List allergies and explain usual reaction and usual treatment:

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\*\*If the usual treatment requires benadryl/Epi-pen/inhalers for allergic/asthmatic reactions, the child must bring it to camp every day. (Please list in medications below.)

Current medications (send with instructions):

Other conditions/health related needs not mentioned above:

**Medication/Authorization**

Provide the following information if your child requires any medication to be administered while at camp. If no medication is to be administered by camp staff, then you may skip this section of the form.

**I give my permission to dispense the following medication(s) to my child:**

Name of Medication (besides Humalog or Novalog):

Time(s) to be given:

**Schedule for blood glucose monitoring:**

Typically campers are checked before lunch and before swimming. In addition, if signs of hypoglycemia or hyperglycemia are present, BG testing will be performed. If you would like additional BG testing to be performed, please specify:

**For those receiving insulin:**

Specify Humalog/Novlog and list your child’s Carb/Insulin ratio and Correction formula.

**Medication/Authorization (con’t)**

**If your child receives injections:**

Are they using an insulin pen and can they perform any care independently, i.e., BG checks or insulin injections?

**If your child is on an insulin pump:**

Specify which pump and what functions your child can perform under the nurses’ supervision.

Will your child be using the Medtronic Minimed 670G pump in auto-mode during Kamp?

□ Yes □ No

**List typical injection or pump sites for your child:**

**Is your son/daughter with diabetes using a continuous glucose monitoring system (CGM)?**

□ Yes □ No If Yes, which brand □ Dexcom □ Minimed

The CGM is displayed on: □ Phone □ Insulin Pump □ Receiver

**Any additional instructions?**

Other persons to whom child may be released (photo ID)

Name:

Address-Zip:

Name:

Address-Zip:

**Emergency Procedures**

The following procedures will be used in caring for your child when he/she becomes ill or injured at camp.

In case of emergency and/or need of medical or hospital care:

1. The camp will call the home. If there is no answer,
2. The camp will call the father’s, mother’s or guardian’s place of employment. If
3. there is no answer,
4. The camp will call the other telephone numbers listed.
5. If none of the above answer, the camp will call an ambulance, if necessary, to
6. transport the child to a local medical facility.
7. Based upon the medical judgment of the health care provider, the child may be
8. admitted to a local medical facility.
9. The camp will continue to call the parents/guardians until one is reached.

**Important: This section must be completed for day camp attendance.\***

This health history is correct so far as I know, and the person herein described has permission to engage in all activities, except as noted. I take full responsibility for any medical problems (illness or injury) that occur as a result of my failure to disclose medical conditions, restrictions, or limitations of my child or those injuries not caused by the University’s negligence.

Signature of Parent/Guardian Date

Authorization for treatment: I hereby give permission to the medical personnel selected by the activity director to order x-rays, routine lab tests, treatment; to release any record necessary for insurance purposes; and to provide or arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the health care provider selected by the camp director to secure and administer treatment, including hospitalization, for the person named above.

Signature of Parent/Guardian Date

If for religious reasons you cannot sign this statement, then the camp should be contacted for a legal waiver which must be signed for attendance.

**IMPORANT INFORMATION!!!**

**After completing this Health Form you MUST mail the completed form to the University of Delaware School of Nursing address below. We will NOT be accepting Health Forms by email.**

**Mailing address:**

**Kamp4Kids**

**University of Delaware School of Nursing**

**25 North College Avenue, McDowell Hall 386**

**Newark, DE 19716**