

LEHIGH VALLEY HOSPITAL – HELWIG HEALTH AND DIABETES CENTER
2007 CAMP RED JACKET
Sponsored by The Loretta Fund
Medical History Questionnaire

Child's Name: _____

Social Security Number: _____ - _____ - _____

Date of Birth: _____

Street Address: _____

City-State-Zip: _____

Parent(s)/Guardian(s) Name: _____

Home #: _____ Work #: _____ Cell Phone: _____

In case of an emergency contact: _____ Contact #: _____

Relationship to child: _____

Child's Physician: _____ Phone #: _____

CAMP EXPERIENCE

Has your child been to a camp before: Yes / No

If so, what type of camp: _____ Day Camp _____ Residential Camp _____ Diabetes Camp _____ Other

MEDICAL HISTORY

Age: _____ Height: _____ Weight: _____ Sex: Male / Female

Please list all allergies:

Food allergies

Medication allergies

Other allergies

How long has your child had diabetes? _____

Are there any other health conditions that we should be aware of? Yes / No If Yes, please list:

Has your child had a Tetanus shot? Yes / No If Yes, what was the date given: _____

How does your child typically react to hypoglycemia (low blood sugar)?

Frequency of hypoglycemia (low blood sugar): Monthly _____ Weekly _____

⇒ Are there any current diabetes issues or current blood sugar problems we should be aware of? Yes / No
If Yes, please list:

INSULIN AND MEDS

A. Is your child using an insulin Pump: Yes / No
If **Yes**, fill in the following information. If **No**, got to B.

Basal Rates: _____

Correction Factor or "Drop Factor": _____ Target Blood Sugars:

Time	Target
_____	_____
_____	_____

Carbohydrate to Insulin Ratio Number: _____

Please pack insulin and additional infusion sets, reservoirs, and batteries in case your child needs a set or battery change during camp.

B. If your child is not on the insulin pump please fill in the following information:

Please list your child's usual insulin dose and schedule:

Insulin	Units	Time of Day
_____	_____	_____
_____	_____	_____

Pre Meal Target Blood Sugar: _____

Correction Factor or "Drop Factor" if you have one: _____

Carbohydrate to Insulin Ratio if you have one: _____

Please pack your child's insulin and syringes or insulin pen(s) and needles in case your child needs insulin during camp.

OTHER MEDICATIONS

Please list names and doses of **all** medications taken by your child:

*(If your child takes any medication that we are to administer during camp, you **must** complete a medication permission form for **each** medication to be given. Please be sure to include the dose and time.)*

METER

What type of meter does your child have?

Please bring your child's meter to camp with you. Label the meter kit clearly with your child's full name. Be sure that there are enough test strips for testing during camp.

⇒ **All children will be tested before lunch. Extra tests may be performed if your child appears to, or complains of having low or high blood sugar.**

