HEALTH EXAMINATION BY LICENSED PROVIDER
2024

(Preferably completed by child's endocrinologist – Must be returned **by May 1, 2024**)

Camper_____Birthdate_____Gender_____Session _____

LAST NAME, FIRST NAME

Date of DM onset_____OR Age at onset_____Date of Last Exam _____

(Must be within the past 12 months)

Height_____cm / in %-tile_____ Weight_____kg / lb. %-tile_____ B/P _____

Other pertinent physical findings _____

Date of Last HbA1c_____ HbA1c _____

History of DKA, Nocturnal Hypoglycemia, Hypoglycemia requiring IV Glucose or IM Glucagon:

(Please include dates) _____

Allergies (must be indicated to be recognized at camp): Reaction to allergens:

_____ _____

_____ _____

_____ _____

_____ _____

Other Medical Conditions _____

Other Medications _____

_____

Activities to be encouraged or limited at Camp _____

Are there any physical, emotional or behavioral health issues which might create a problem for him/her at camp?

_____

Provider: PLEASE ATTACH A COPY OF THE PATIENT'S MOST UP TO DATE INSULIN REGIME AND INDICATE IF PARENT/GUARDIAN IS ALLOWED TO MAKE SMALL CHANGES ON THIS REGIME

Licensed Provider's Signature _____

Date of Completion _____

By_____(initial if completed by nurse/asst.)

Stamp required here

Revised 9/2023

P.O. Box 156 910 Saddleback Road Stillwater, NJ 07875-0156

Phone: (973) 383-2611 Fax: (973) 383-9891 information@campnejeda.org