DIABETES DOCTOR MEDICAL FORM

To Be Filled Out By A Licensed Physician And Returned To: TCDC, 1854 Joseph Ter., Hixson, TN 37343

Campers Name_____ **Campers Date of Birth**_____

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Insulin Pump Yes ____ No _____ Pump Brand _____

If necessary to remove from a pump, or pump failure, what would your insulin preference be? _____

Continuous Glucose Monitoring Yes _____ No _____ Type of CGM _____

Long-Acting Insulin _____ Short-Acting Insulin _____

Sensitivity Factor _____ Correction Factor _____

Insulin Carb Ratio _____ HgbA1c _____ Date _____

Insulin injection sites issues: _____

What problems, if any, has this patient been having with the management of his/her diabetes?

_____

_____

Other medical history: _____

_____

Recommendations and/or restrictions while in camp: _____

_____

Describe any known PSYCHOLOGICAL problems, disorders or admissions. Please note any emotional stresses which might impact patient's behavior at camp:

_____

_____

General Appraisal: _____

_____

I UNDERSTAND THAT I AM BEING ASKED TO CERTIFY THAT THE PERSON HEREIN DESCRIBED HAS NO CONTRAINDICATION, WHETHER PHYSICAL, EMOTIONAL, OR MENTAL, FOR PARTICIPATION IN CAMP ACTIVITIES. I CERTIFY THAT, UPON EXAMINATION OF THE PERSON HEREIN DESCRIBED, AND A REVIEW OF HIS/HER HEALTH HISTORY, NO PHYSICIAL, EMOTIONAL, OR MENTAL CONTRAINDICATION EXISTS, IN MY OPINION, WHICH WOULD PREVENT SUCH PERSON FROM BEING ABLE TO ENGAGE IN CAMP ACTIVITIES, EXCEPT AS SPECIFICALLY NOTED ON THIS FORM.

_____ _____ _____

PHYSICIAN'S SIGNATURE Printed Name Date of Examination

Address: _____

City_____, _____ Zip Code _____

Telephone Number (_____) _____

Fax Number (_____) _____

PRIMARY CARE MEDICAL FORM

To Be Filled Out By A Licensed Physician And Returned To: TCDC, 1854 Joseph Ter., Hixson, TN 37343.

Campers Name_____ **Campers Date of Birth**_____

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Code: √ = Satisfactory X = Not Satisfactory (explain) 0 = Not Examined

PLEASE CIRCLE THE APPROPRIATE CODE AND DESCRIBE ABNORMAL FINDINGS

Eyes	√ X 0	Lungs	√ X 0
Glasses/contacts	√ X 0	Abdomen	√ X 0
Ears	√ X 0	Extremities	√ X 0
Nose	√ X 0	Spine	√ X 0
Teeth	√ X 0	Skin	√ X 0
Throat	√ X 0	Allergy	√ X 0
Heart	√ X 0	Pubertal?	_____ Yes _____ No

Other medical history: _____

_____

Recommendations and/or restrictions while in camp: _____

_____

_____

Describe any known PSYCHOLOGICAL problems, disorders or admissions. Please note any emotional stresses which might impact patient's behavior at camp:

_____

_____

_____

General Appraisal: _____

_____

_____

I UNDERSTAND THAT I AM BEING ASKED TO CERTIFY THAT THE PERSON HEREIN DESCRIBED HAS NO CONTRAINDICATION, WHETHER PHYSICAL, EMOTIONAL, OR MENTAL, FOR PARTICIPATION IN CAMP ACTIVITIES. I CERTIFY THAT, UPON EXAMINATION OF THE PERSON HEREIN DESCRIBED, AND A REVIEW OF HIS/HER HEALTH HISTORY, NO PHYSICIAL, EMOTIONAL, OR MENTAL CONTRAINDICATION EXISTS, IN MY OPINION, WHICH WOULD PREVENT SUCH PERSON FROM BEING ABLE TO ENGAGE IN CAMP ACTIVITIES, EXCEPT AS SPECIFICALLY NOTED ON THIS FORM.

_____ _____ _____

PHYSICIAN'S SIGNATURE Printed Name Date of Examination

Address: _____

City_____, _____ Zip Code _____

Telephone Number (_____)_____

Fax Number (_____)_____