

DIABETES YOUTH FOUNDATION OF INDIANA

CAMP HEALTH FORM

PART A: HEALTH HISTORY

Completed by Parent/Guardian

nper's Full Name:					
	Please attach copy of imnus date is not available, medical pers	uunization record connel will be allowed to adm	ninister		
	. HISTORY: CIRCLE ALL THAT APF				
Recent illness or infectious disease		Head Injury/Concussion	Depression or Anxiet		
Asthma	Mononucleosis (in last 3 months)	Eating Disorder	Autism		
Frequent Ear Infections	Joint Problems (knees, ankles)	Diarrhea or Constipation	Celiac Disease		
Seizure Disorder	ADHD or ADD	Recent Hospitalization	Hypothyroidism		
Heart Defect or Disease	Fractures	Sleep Walking	Hyperthyroidism		
Hypertension	Frequent Headaches	Bed Wetting	Hearing Impairment		
Eczema			Other (Note Below)		
Allergies:					
Allergies: If yes, does camper DAILY MEDICATIONS (OTH	use a auto injector? YES NO ER THAN INSULIN)				
Allergies: If yes, does camper	use a auto injector? YES NO		Administration Time		
Allergies: If yes, does camper OAILY MEDICATIONS (OTH	use a auto injector? YES NO ER THAN INSULIN)		Administration Time		
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PART B: PRE-PARTICIPATION PHYSICAL

Completed by Primary Care Provider

Camper's Full Name				Date of Bir	th	_/	_/	
Date of Physical:		(N	(Must be within last 12 months)					
Height (in.): _): Weight (lbs.):			BP:	/_			
UEFNIT	Normal Abnor	rmal Abnormal		Please explain any abnormalities:				
HEENT								
LUNGS								
HEART								
ABDOMEN								
MUSCULOSKELETAL								
NEUROLOGICAL								
SKIN OTHER								
VINLK								
Does patient have a history	of asthma?	YES NO	If yes, p	olease attach cu	urrent Ast	hma Actio	on Plan	
Does patient have a history	of allergies requi	ring epinephrine?	NO	YES (Please e	xplain)			
								_
I have reviewed and agree with Part A: Health History?		NO	YES (with the following exceptions/additions:					
Are there any medical restrictions to participation at camp?			NO	YES (Please explain)				
During the child's stay at cam endocrinologist, however if yo								– /her –
I approve of this child attend	ding Camp Until a	a Cure. YES	NO					
Provider Signature:								
Provider's Printed Name:				D	ted forms YFIemily Faxed to:	@gmail.	com	:o:
					or Mailed DYFI, 5050 E.			
Dhana	F				Noblesvil	le, IN 46	060	