Barton Day Camp Session:
Rainbow___ Boston___
Worcester___ Western NE___
Mt. Sinai/Barton___
Long Island 1__Long Island 2___

The Barton Center for Diabetes Education, Inc.
PO Box 356, North Oxford, MA 01537
(508) 987-2056 www.bartoncenter.org

2014 HEALTH FORM – Day Camper

Last Name: _____ First Name: _____ Middle Initial: _____
Address: _____ City:_____ State:_____ Zip:_____
Date of Birth: _____ Age: _____ Gender: _____

Primary Health Care Provider: _____
Mailing Address: _____ Phone: _____
Primary Diabetes Care Provider: _____
Mailing Address: _____ Phone: _____
Mental Health Provider _____
Mailing Address: _____ Phone: _____
Dentist: _____
Mailing Address: _____ Phone: _____

EMERGENCY CONTACT INFORMATION:
Name:_____ Relationship:_____ Phone:_____
OR Name: _____ Relationship:_____ Phone:_____

PLEASE PROVIDE COPIES OF FRONT AND BACK OF ALL INSURANCE AND PRESCRIPTION CARDS.

IMMUNIZATION RECORD: Please initial if attached:_____

Tetanus _____ Meningococcal _____ Influenza _____ Pneumococcal _____
Hepatitis B _____ Inactivated Poliovirus _____ Measles, mumps, rubella _____
Varicella _____ Hepatitis A _____ TB test _____

PRESENT HEALTH CONCERNS:

1. _____
2. _____
3. _____
4. _____

MEDICAL HISTORY: **Medications (other than insulin):**

	Medication	Dosage	Time
1.			
2.			
3.			
4.			
5.			
6.			

Supplements: (please list vitamins, minerals, herbs, and homeopathic remedies)

1.
2.
3.
4.

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Allergies:

		Allergy	Reaction
Medication:	1.		
	2.		
	3.		
Environment	1.		
	2.		
Food:	1.		
	2.		

CHILDHOOD ILLNESSES:

ADD/ADHD	No	Yes	Asthma	No	Yes
Anxiety	No	Yes	Eating Disorder	No	Yes
Depression	No	Yes	Learning or Developmental disorder	No	Yes
Bedwetting	No	Yes	Problems sleeping	No	Yes
Constipation	No	Yes	Seizures	No	Yes
DKA	No	Yes	Severe low blood sugar	No	Yes

If Yes, tell us about it:

_____

_____

Most Recent A1C _____ Date _____How does your child manage his/her diabetes?

_____

SERIOUS INJURIES AND/OR ACCIDENTS

Type	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical or Emotional HOSPITALIZATIONS/SURGERIES/COUNSELING

Reason for Hospitalization	Date
_____	_____
_____	_____
_____	_____

Do we have permission to speak with your child's mental health/diabetes/other health care providers? YES NO

I authorize The Barton Center for Diabetes Education, Inc. to release or receive all medical records, for the above-named camper, including but not limited to those records pertaining to substance abuse and emotional or mental health.

I hereby give permission to the health care provider selected by the Camp Physician to order X-rays, routine tests, and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the health care provider selected by the Camp Physician to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.

Parent/Guardian Signature: _____Date: _____