

DIABETES DOCTOR MEDICAL FORM

**To Be Filled Out By A Licensed Physician And Returned To: TCDC, 1854 Joseph Ter., Hixson, TN 37343
Fax (423) 370-1539**

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 _____ HgbA1c _____

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 PHYSICAL, 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 (_____) _____

