Participant's Name: _____

*updated October 2022

Physician's Statement & Medical History

****Must be completed and signed by physician****

DOB: _____ Height: _____ Weight: _____lbs

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Special Precautions/Needs: _____

Mobility please circle one: Independent Ambulation or Assisted Ambulation Device used: _____

Type of Home Glucose Meter used: _____

Value of last A1C: _____ Date: _____

Please indicate current or past special needs in the following, including surgeries:

Systems/ areas	Y	N	Questions	Y	N
Auditory	☐	☐	Does camper control diabetes?**	☐	☐
Visual	☐	☐	Is camper compliant with dietary management?**	☐	☐
Tactile Sensation	☐	☐	Is camper compliant with insulin management?**	☐	☐
Speech	☐	☐	Does camper test his/her blood sugar regularly?**	☐	☐
Cardiac	☐	☐			
Circulatory	☐	☐	Is camper prone to Ketoacidosis?	☐	☐
Integumentary/ Skin	☐	☐	Is camper prone to hypoglycemia?	☐	☐
Immunity	☐	☐	Is camper prone to unrecognized hypoglycemia?	☐	☐
Pulmonary	☐	☐	Is camper prone to hypoglycemic seizures?	☐	☐
Neurologic	☐	☐			
Muscular	☐	☐	Does camper need extra supervision with testing, insulin, or diet?	☐	☐
Balance	☐	☐			
Orthopedic	☐	☐			
Allergies	☐	☐			
Learning Disabilities	☐	☐	**All campers are supervised with these procedures at Camp Red Cedar**		
Cognitive	☐	☐			
Emotional/ Psychological	☐	☐			
Pain	☐	☐			
Other	☐				

Both boxes need checked for Equestrian & Camp Participation.

☐ **Given the above diagnosis and medical information, there is no reason why this person cannot participate in supervised equestrian activities and/or therapies.**

☐ **I approve of this camper attending Explorer (Juvenile Diabetes) Camp.**

Therefore, I refer this person to Camp Red Cedar for ongoing evaluation to determine eligibility for participation.

Physician Name and title (please print) _____ ○MD ○DO ○NP ○PA

Physician Signature _____ Date: _____

Address _____ City _____ State _____ Zip _____

Phone (____) _____ License/UPIN Number: _____