American Diabetes Association. Camps

Physician Evaluation Form - Diabetes

Parent/Guardian (P/G) Instructions:

1. Fill out ALL information in this top box. 2. Give this form to your health care provider to fill out the remaining information about your child's diabetes care. This form is **REQUIRED** for your child to attend an ADA camp program. 3. Send fully completed form to the ADA. See bottom of this form for return instructions. (Health care provider may send form to ADA on P/G's behalf)

Camper First Name _____ **Camper Last Name** _____

Camper Date of Birth: _____ **Gender (Circle One):** M F O

(P/G) First & Last Name: _____ **ADA Camp(s) Name(s):** _____

(P/G) Primary Phone: _____ **(P/G) Email:** _____

- INFO BELOW MUST BE COMPLETED & SIGNED BY DIABETES HEALTH CARE PROVIDER (MD, DO, NP, PA-C) -

Date of Exam		**Current Height**	
Date of Diagnosis		**Current Weight**	
Insulin Delivery (Circle)	Pump MDI	**Latest HbA1C**	

List the 4 most recent A1C results. For newly diagnosed patients provide available information.

Date				
HbA1C				

Complete the below questions with accuracy, this information is essential to the Camp Medical Team.

Question	Circle One	If yes, provide further explanation or relevant notes.
Has the child or family been in counseling over the past year? Has the camper or family been referred to counseling? If yes, explain the nature of the problem.	Yes No	
Do you have any concerns regarding the management of this child's diabetes or health at Camp?	Yes No	
Is there any prior history of suicidal ideation or attempt?	Yes No	
Is this patient in a clinical trial that will require specific medical treatment or care at Camp?	Yes No	*IF YES, ATTACH SPECIFIC TRIAL INFORMATION*
Do you have any suggestions for the care of this child at Camp or for areas of diabetes management and education focus?	Yes No	
Is this patient on any diabetes medications besides insulin?	Yes No	
Have any complications of diabetes or disabilities been detected?	Yes No	
Do you recommend any limitations on this child's activity while at Camp?	Yes No	
Are there any reasons that you feel your patient should not participate in the ADA Camp Program?	Yes No	
Does this camper have any dietary restrictions?	Yes No	
Does the camper have a CGM?	Yes No	*IF YES, WHAT SYSTEM?
Is the camper's CGM integrated with an insulin delivery system?	Yes No	

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CAMPER NAME: _____

CURRENT INSULIN PRESCRIPTION—Please fill out or attach current regimen from EMR.

Target Glucose Range:

Breakfast		Bedtime	
Lunch		Other:	
Dinner		Other:	

Correction Factor : (Example: 1 unit to lower BG every 50 mg/dl)

Pre-Breakfast		Pre-Bedtime	
Pre-Lunch		Other:	
Pre-Dinner		Other:	

Multiple Daily Injection (MDI) Users

Mealtime/Fast Acting Insulin: Please circle

Humalog	Apidra	Novolog
Fiasp	Humulin—R	Novolin –R
Other:		

Mixed Insulin Only: List the units prescribed

Brand/Name	Breakfast	Lunch	Dinner	Bedtime

Insulin to Carb Ration by Meal:

	Ratio		Ratio
Breakfast		AM Snack	
Lunch		PM Snack	
Dinner		Bedtime	

Basal/Long Acting Insulin:
Please specify dose (in units) and administration time.

	Breakfast	Lunch	Dinner	Bedtime
Levemir				
Lantus				
Basaglar				
Humulin—N				
Novolin—N/NPH				
Tresiba				
Toujeo				
Other :				

Pump Users

Insulin Pump Brand & Model:

Pump Insulin Type: Please circle

Humalog	Apidra	Novolog
Humulin—R	Fiasp	Other: _____

Insulin to Carb Ration by Meal:

	Ratio		Ratio
Breakfast		AM Snack	
Lunch		PM Snack	
Dinner		Bedtime	

Basal Insulin Settings:

Midnight		8:00 AM		4:00 PM	
1:00 AM		9:00 AM		5:00 PM	
2:00 AM		10:00 AM		6:00 PM	
3:00 AM		11:00 AM		7:00 PM	
4:00 AM		Noon		8:00 PM	
5:00 AM		1:00 PM		9:00 PM	
6:00 AM		2:00 PM		10:00 PM	
7:00 AM		3:00 PM		11:00 PM	

HCP Printed Name:	
HCP Office Phone:	
HCP Email:	
Office Name/Org:	
HCP Fax Number:	
Office Address:	

City:		**State:**		**Zip:**	

Provider Signature :		**Today's Date:**	

Return Instructions

ATTN: ADA Camps
Fax: 720-855-1302
Email: amcculloch@diabetes.org

Mail: 2460 West 26th Avenue,
Suite 500C
Denver, CO 80211