CAMP SEALE HARRIS
SOUTHEASTERN DIABETES EDUCATION SERVICES

Please return completed form to:
Camp Seale Harris
500 Chase Park South, Suite 104
Birmingham, AL 35244
Phone – 205-402-0415
FAX – 205-402-0416
Email – info@campsealeharris.org

Date of Examination

_____

Date of Diabetes Diagnosis

_____

Medical Examination
Form CSH/SDES 2021

Examination to be completed by a licensed physician within 120 days of program attendance.

Child's Name _____ Date of Birth _____

___ Type 1 Diabetes ___Type 2 Diabetes, Insulin Requiring ___Type 2 Diabetes, Non-Insulin Requiring

Last Hgb A1C _____ Date ___/___/___ Moderate/Large Ketone Insulin Dose Used at Home _____

Does the child have any physical condition(s) requiring restriction(s) on participation in the camp program? If so, please describe: _____

_____

_____

_____

_____

Is the child taking any current or on-going treatment(s) or medication(s)? If so, please describe:_____

_____

_____

_____

_____

Other Comments:_____

_____

_____

_____

Examining Physician Statement

I have examined this child and his/her medical history and find that he/she is able to attend Camp Seale Harris programs and participate in the activities except as noted above. I understand that insulin dosages may be changed by the camp physician as required by glucose values.

_____ _____

Physician Signature Date

_____ (_____) _____

Physician Name (Please print) Telephone