



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 - sarah@campsealeharris.org

Date of Examination  
\_\_\_\_\_

Date of Diabetes Diagnosis  
\_\_\_\_\_

### Medical Examination Form CSH/SDS 2022

Examination to be completed by a licensed physician within 6 months 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(any information that will help us care for this camper while at camp): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 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