American Diabetes Association.

Camp Carefree

DUE MARCH 30, 2017

COUNSELOR/THERAPIST/PSYCHIATRIST QUESTIONNAIRE

To be completed by camper's mental health care provider

Please complete sign, date and return to:

Wendy Pack, Camp Coordinator
ADA Camp Carefree
PO Box 2118
Wolfeboro, NH 03894

FAX: 617-507-3471
EMAIL: wendy@campcarefreekids.org

NOTE: Any delay in returning this form may result in your patient being placed on a waiting list.

To Parent: Please complete/sign this box before forwarding to health professional.

Patient's Name_____

Patient's Date of Birth _____

Parent/Legal Guardian Name _____

Address_____

_____

As the parent/legal guardian, I freely give permission to my child's therapist/counselor to release information pertaining to my child to the American Diabetes Association for their use at Camp or speak with the ADA representative concerning my child's treatment.

_____ _____

Signature of Parent/Legal Guardian Date

1. How long have you known your patient? _____
2. Has your patient been compliant in attending appointments? □ Yes □ No
3. Does he/she pose any danger to him/herself or others? □ Yes □ No
   If yes, please explain.
4. Is there any prior history of suicidal ideation or attempt? □ Yes □ No
   If yes, please explain.

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5. Is your patient on any psychiatric medications? □ Yes □ No
   If yes, please list the medication(s), strength and dosage:

6. Please list any specific recommendations that would be helpful in the care of your patient for the Camp medical staff.

7. Are there any reasons that you feel your patient should *not* participate in the American Diabetes Association summer Camp program? □ Yes □ No

   If yes, please explain.

8. Would you be willing to be contacted, if necessary, by telephone during camp session **(7/23-8/5/17)** should a problem arise? □ Yes □ No (This will only be done if absolutely necessary.)

   If yes, please include your answering service or home telephone number with area code below.

   Phone Number: (_____)_____

During your patient's stay at Camp, he/she will be monitored as closely as conditions permit. No alterations in management will be made without due consideration by the medical staff. The medical staff consists of experienced medical, family practice, and pediatric residents, nurses, and dietitians, under the direct medical supervision of an attending physician.

_____ _____ _____

Please print name Signature Date

Address: _____

_____

_____

City State Zip

Thank you for your cooperation. If you have any questions or comments,

please call Phyllis Woestemeyer, Director, at 732-752-1715

NOTE: All information submitted to the American Diabetes Association will be kept private and confidential.