American Diabetes Association®

Diabetes Camp Application – 2011

I acknowledge that with this submission I agree to pay the camp fee due prior to attendance at the event unless aid is awarded.

CAMPER'S NAME: _____

Primary Household Information:
(Provide contact details below for the first parent or guardian living at the SAME address as the Camper)

Parent/Legal Guardian #1: Title: Mr Mrs Ms Miss

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____
Cell / Pager: _____ Email: _____

(If applicable, provide contact details below for the second parent or guardian living at the SAME address as the Camper)

Parent/Legal Guardian #2:
Title: Mr Mrs Ms Miss

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____
Cell / Pager: _____ Email: _____

Emergency Contact Information
(Emergency contact for the week other than parent):

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____
Cell Phone / Pager: _____

Secondary Emergency Contact:
Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____
Cell Phone / Pager: _____

Family Status Information

Are child's parents divorced/legally separated? ☐ Yes ☐ No	If yes, which parent has legal custody: ☐ Mother ☐ Father ☐ Joint ☐ Other If Other, what is relationship to camper?
Child resides with: ☐ Mother ☐ Father ☐ Other (list relationship)	
Mother's/Guardian's Employer/Fax #:	**Father's /Guardian's Employer / Fax #:**

American Diabetes Association®

Diabetes Camp Application – 2011

CAMPER'S NAME: _____

Is either parent/guardian or child an American Diabetes Association Member? ☐ **YES** ☐ **NO**
Is either parent/guardian a member of the ADA camp staff? ☐ **YES** ☐ **NO**

Child's County/Parish of Residence:_____

Are you requesting financial assistance? ☐ Yes ☐ No

CAMPER INFORMATION

Name: Last, First, M.I.	**Nickname,** if used:
Birth date: Day/Month/Year	**Gender:** ☐ **Male** ☐ **Female**
Current Grade:	**School Name:**
Email (for camper directory)- not mandatory	**T-Shirt Size:** ☐ Youth M ☐ Youth LG ☐ Adult S ☐ Adult M ☐ Adult L ☐ Adult XL ☐ Adult XXL
Swim Level: ☐ Non-swimmer ☐ Beginner ☐ Intermediate ☐ Advanced	
Ethnicity: ☐ Caucasian ☐ African American ☐ Latino ☐ Asian American ☐ Native American ☐ Eskimo ☐ Pacific Islander ☐ Multi Racial ☐ Alaskan Native ☐ Native Hawaiian ☐ Other:	
1st Time Camper? ☐ YES ☐ NO	
How did you learn about Camp? (Referral Source) ☐ Physician ☐ Diabetes Educator ☐ Friend ☐ School ☐ Family member ☐ Ad ☐ Word of Mouth ☐ Brochure ☐ Internet ☐ Other (list):	
Name of Child's Health Insurance Company	**Policy #:**
	Policy Holder:
Name of Primary Care Provider: Last, First	**Office Phone with Area Code:**
Type of Diabetes ☐ type 1 ☐ type 2 ☐ Pre-diabetes ☐ Metabolic Syndrome ☐ Sibling - non diabetic ☐ Friend - non diabetic	**Month / Year of Diabetes Diagnosis:** _____/_____
Any activity restrictions? ☐ Yes ☐ No If yes, please list:	

American Diabetes Association®

Diabetes Camp Application – 2011

CAMPER'S NAME: _____

METER INFORMATION

Brand & Model Name of Meter Used: _____

INSULIN INFORMATION

Brand, Types & Method used: **Circle all that apply**. For method, circle
V for Vial if using pump or syringes, **P** for Pen (disposable) or **C** for Cartridge (for Non-Disposable Pen)

Brand: Lilly		**Brand: Novo-Nordisk**		**Brand: Sanofi-Aventis**	
Type	**Method**	**Type**	**Method**	**Type**	**Method**
Humalog	V P C	Novolog	V P C	Lantus	V P C
Humulin R	V P C	Novolin N	V P C	**Brand: Sanofi-Aventis**	
Humulin N	V P C	Novolog Mix 70/30	V P C	**Type**	**Method**
Humulog Mix 50/50	V P C	Levemir	V P C	Apidra	V P C
Humalog Mix 75/25	V P C	ReliOn	V P C		
Humulin 70/30 (N/R)	V P C				

If you use any other insulin, please list brand, type, and Method used:

Does child use a CGM (Continuous Glucose Monitoring) ☐ Yes ☐ No	If yes, please list Brand:
Is specific meter required for calibration of CGM ? ☐ Yes ☐ No If yes, Brand & Model Name of Blood Glucose Meter Used:	

INSULIN DELIVERY SYSTEM

Complete information only for what your child uses: Pump, Pen or Syringe	
1. Insulin Pump Brand & Model Name:	
Infusion Set Used:	Tubing Length Used:
Start Date: Year: _____ Month: _____	Pump Serial Number:
2. Syringe Brand: Syringe Size: Needle Length:	
3. Insulin Pen Brand Name: Needle Length Used:	
Insulin Pen is: □ Disposable pre-filled pen □ Non-disposable pen	

American Diabetes Association®

Diabetes Camp Application – 2011

CAMPER'S NAME: _____

OTHER MEDICATIONS: ATTACH ADDITIONAL PAGE IF NEEDED

Name of Medication	Amount Taken	Time(s) Taken	Purpose/Additional Information

DIABETES SKILLS

Does Camper :	**Yes**	**No**	**Yes, with assistance**	**Additional Information**
Draw up insulin:				
Rotate Injection Sites:				
Give own injections:				
Makes appropriate food choices:				
Test blood sugar:				
Change pump site:				
Recognize own low blood sugar symptoms:				
Recognize own high blood sugar symptoms:				
Exercises regularly:				
Calculate & Apply correction factor for high blood sugar:				
Understands and operates pump screens:				
Administers boluses:				
Understands carb-to insulin ratio:				
Accurately counts carbs				

For any of the Diabetes Skills above with a response of No or Yes with assistance , please provide Additional Information

American Diabetes Association®

Diabetes Camp Application – 2011

CAMPER'S NAME: _____

What 2 new diabetes skills would you like your child to learn or improve? 1.	
2.	
What is the frequency of low blood sugar reactions? ☐ Occasional ☐ Frequent	
What is severity of low blood sugar reactions ☐ Mild ☐ Severe	
Date of last unconscious low blood sugar (if applicable; if not list N/A)	Date of last low blood sugar seizure (if applicable; if not, list N/A)

ALLERGIES / MISCELLANEOUS MEDICAL INFORMATION

Does your child have allergies? ☐ Yes ☐ No If yes, please list:
List Allergies to Medication:
List Other Allergies (food allergies go under Nutrition Information)
Does your child have chronic health conditions/disabilities (excluding diabetes)? ☐ Yes ☐ No If yes, please list:

Does child experience any of the following?	
Frequent colds/sore throats	☐ Yes ☐ No
Athlete's foot	☐ Yes ☐ No
Hives/ Poison Ivy/ Rashes	☐ Yes ☐ No
Has child had any surgeries of which staff should be aware?	☐ Yes ☐ No
Has female child begun menstruation	☐ Yes ☐ No If no, has she been told about it?

Please attach Current Immunization Record*

SPECIAL CONDITIONS/SERVICES

Does child have or receive the following:	**YES**	**NO**	**Explanation/How Treated**
Occupational Therapy			
Physical Therapy			
Hearing Impairment			
Educationally or Behaviorally Disabled			
Speech Impairment			
Attention Deficit Disorder			
Attention Deficit Hyperactivity Disorder			
Visual Impairment			
Cystic Fibrosis			
Asthma			

American Diabetes Association®

Diabetes Camp Application – 2011

CAMPER'S NAME: _____

SPECIAL CONDITIONS/SERVICES (CON'T)

Does child have or receive the following:	YES	NO	Explanation/How Treated
Mental Retardation/Cognitively Challenged			If yes, please list at what age child functions.
Non-ambulatory			
Cerebral Palsy			
Seizure Disorder/Epilepsy			
Bedwetting			
Prophylactics/Assistance Devices			
Diabetes Complications			
Asperger			
Down Syndrome			
Tourette's			
Autism			
Non – English Speaking - List languages(s) spoken			
Require special services/IEP plan/one-on-one care at school			
Drug, alcohol, behavior or other addictions			
Has child ever been hospitalized / institutionalized for drug, alcohol, behavioral or other issues?			If yes, list dates.
Sexually Active (Explanation not needed)			
Nightmares/Talks/Walks in Sleep			
Child requires one-on-one supervision			
Other Needs			
Traveled outside the United States in the past year?			If yes, list countries.

PSYCHOLOGICAL ISSUES

Has/Is your child:	YES	NO	If yes, please explain
Been in counseling within the past year? If yes, please complete the Counselor/Therapist/ Psychiatrist/ Psychologist Questionnaire			
Name of Psychiatrist/ Psychologist /Therapist or Counselor (First and Last Name): Address: Do we have permission to contact psychiatrist/psychologies/therapist/counselor? Daytime Phone:			

American Diabetes Association®

Diabetes Camp Application – 2011

Camper Name _____

PSYCHOLOGICAL ISSUES (CON'T)

Currently in a residential treatment facility? If yes, please complete the Counselor/Therapist/ Physician Questionnaire			
Behavioral Concerns?			
Additional Information			

SOCIAL ISSUES

Does your child:	Always	Sometimes	Never
Make friends easily			
Enjoy interacting with peers			
Relate well in groups			
Relate well one to one			
Express feelings openly			
Follow instructions well			
Enjoy school			
Been a member of group activities			
Get angry easily			
Yell/scream when told no			
Touches objects after being told no			
Hits adults			
Urinates in inappropriate places			
Destroys things			
Hits/bites/kicks other children			
Runs away in stores/playgrounds/etc.			
Experiences homesickness (give symptoms)			

Have any special fears
Please list/explain

Overall child's behavior is
☐ Appropriate ☐ Hyperactive ☐ Withdrawn ☐ Aggressive

List child's favorite sports:

List child's favorite hobbies:

Is this child's first time away from home? ☐ Yes ☐ No
If No, what is the longest period of time away from parents?

What discipline methods do you use at home?

What is typical physical activity level per day?
☐ 1-3 Hours ☐ More then 3 hours ☐ Less then 30 minutes

American Diabetes Association®

Diabetes Camp Application – 2011

CAMPER'S NAME: _____

DIABETES HEALTH CARE PROVIDERS

Name of RN /Diabetes Educator(if applicable; if not mark N/A):		
Address:		
Office Phone:	Fax:	Email:

Name of Dietitian / Diabetes Educator (if applicable; if not mark N/A):		
Address:		
Office Phone:	Fax:	Email:

Name of Social Worker/Child Care Worker (if applicable; if not mark N/A)		
Address:		
Office Phone:	Fax:	Email:

NUTRITION INFORMATION

Child's Meal Plan:

Does your child use Carbohydrate Counting? ☐ Yes ☐ No If No, skip following questions	
Total Recommended Grams of Carbohydrate per day:	
***Optional:* Detail of Grams of Carbohydrate per meal**	
Breakfast	
Mid morning snack	
Lunch	
Afternoon snack	
Dinner	
Bedtime Snack	

Does your child use the Exchange System? ☐ Yes ☐ No If No, skip following questions						
Exchanges per meal/snack	Meat	Fats	Milk	Starches	Fruits	Total Carbs per Meal
Breakfast						
Mid morning snack						
Lunch						
Afternoon snack						
Dinner						
Bedtime Snack						

American Diabetes Association®

Diabetes Camp Application – 2011

CAMPER'S NAME: _____

NUTRITION INFORMATION (CON'T)

Does your child use **both** exchanges & carbohydrate counting? ☐ Yes ☐ No If No, skip following questions
Total Recommended Calories per day:
Total Carbohydrates per day:

Does your child have:	**Yes**	**No**	**Details**
Obsession with food			
Fear of eating			
Pica (eating non-food items)			
Evidence of vomiting			
Concern with chewing			
Strong preference for liquids over solids			
Minimum variety			
Bulimia			
Anorexia			
Celiac Disease			
Lactose Intolerance			
Skips Meals			
Uses food as manipulation			
Uses the Exchange System			
Use other Meal Plan			
Food Allergies (not dislikes)			
Food Intolerances (Child dislikes (but is not allergic to)			
Special Dietary Needs other than diabetes			

If your child uses any other meal plan, please explain:	
Date of last visit to dietitian or nutritionist	

Child's Height:	Child's Weight:

American Diabetes Association®

Diabetes Camp Application – 2011

CAMPER'S NAME: _____

Camper/Parent Behavior Contract
Concerning Rules & Expectations at Camp

I will stay on the property during the camping session.

I will not intentionally injure or endanger myself or any other person either physically or emotionally. This includes keeping my blood sugar extremely high or low on purpose.

I will respect the environment, Camp, property of Camp and personal property of others. If I do not, my family will be responsible for damages caused.

I will not use bad / inappropriate language.

I will not engage in any sexual contact or use language of a sexual nature

I will not use tobacco products, drugs, alcohol, or weapons.

I will demonstrate respect for staff and fellow campers at all times.

I will not engage in teasing, harassment or ethnic /racial /religious/political slander of any person or group.

If I am with someone who is breaking one of the above rules, I can also be dismissed.

If I do not follow these rules, I

1) Can be promptly dismissed from Camp.
2) Must have parent/guardian come to Camp to pick me up.
3) Forfeit all Camp fees.
4) Risk losing the privilege of returning to Camp in the future.

I have read and understand the rules and will help enforce them. In addition, I have read and explained the Camp rules to my child and believe that he/she understands them. I agree to pick my child up from Camp if he/she breaks this contract.

I will treat all campers and staff during and after Camp with respect. This means that I will not participate in any phone, online, email, instant messaging or text messaging of a threatening, bullying or inappropriate nature prior to, during or after camp. If I do, I may not be allowed to attend Camp.

_____ _____
Camper Signature Parent/Guardian Signature

_____ _____
Date Date

American Diabetes Association®

Diabetes Camp Application – 2011

Camper Medical Form / Health Evaluation
To be completed by camper's diabetes health care provider

Dear Doctor:
Your cooperation in supplying the following information about an applicant for **ADA Alaska Diabetes Camp** will be greatly appreciated. **The child will not be accepted at Camp without this form.**

To Parent: Please complete boxed information BEFORE submitting to Physician

Name of applicant: _____ Gender: (circle one) M F

Date of Birth: ___/__/___

Date of Exam:_____

Last hemoglobin A1C: _____(lab normal range _____) Date: _____

Target Blood glucose range: Pre-breakfast _____ Pre-lunch _____
Pre-supper _____ Bedtime _____
What is child's nutrition program? _____

Current Weight_____ Current Height:_____

Is child on a continuous glucose monitoring system? ☐ Yes ☐ No
If yes, what system? _____

Is camper in a clinical trial that will require specific medical treatment/care at Camp?
☐ Yes ☐ No If yes, please **attach** specific information.

Please Note: It may be necessary, with more exercise to increase caloric intake. This will be done under the Camp physician's supervision and noted in the camper's chart.

INDICATE THE LAST PRESCRIBED INSULIN DOSE FOR THE CHILD
If child is on a pump, please list insulin to carb ratio for each meal/snack

UNITS/TYPE (per grams of carbohydrate if applicable)

Before Breakfast _____ Before Lunch _____

Before Supper _____ Before Bedtime _____

Morning Snack _____ Afternoon Snack _____

Bedtime Snack _____

American Diabetes Association®

Diabetes Camp Application – 2011

PLEASE CIRCLE ALL THAT APPLY:

Lilly — Humalog, Humulin N, Humulin R, Humulin 70/30,

Humalog Mix 75/25, Humalog Mix 50/50

Novo-Nordisk (Novolin) — Novolog , Novolin N, Novolog Mix 70/30, Levemir,

Sanofi-Aventis — Lantus Apidra

Other Insulin (List Brand & Type)_____
Pen (List Brand and model)_____
Pump: List brand and model: _____

What is the correction dose of insulin prescribed for high glucose boluses? (e.g. 1 unit per 50 mg/dl for BG>140)

_____

Note: If insulin dose is changed during Camp, parent will be notified at departure interview.

Have any complications of diabetes or disabilities been detected? ☐ Yes ☐ No
If yes, please specify:_____

Emotional Status: It is imperative that the Camp medical team be aware of any family or camper emotional problems which may affect the camper's health at Camp or the health and safety of other campers and staff.

Has the child or family been in counseling over the past year? ☐ Yes ☐ No
Has the family been referred for counseling? ☐ Yes ☐ No
If yes, what is the nature of the problem?

_____

Do you have any specific concerns regarding the management of this child's diabetes or health at Camp? ☐ Yes ☐ No If yes, please explain:

_____

Do you have any suggestions for the care of this particular child at Camp or for areas of diabetes management and education focus? ☐ Yes ☐ No If yes please explain:

_____

Do you recommend any limitations on child's activity while at Camp? ☐ Yes ☐ No
If yes, please describe:_____

Are there any reasons that you feel your patient should not participate in the American Diabetes Association summer Camp program? ☐ Yes ☐ No If yes, why not?

_____

Physician's name (typed or printed) _____

Address: _____Phone: (___) _____

Physician's Signature: _____

Mail Form To: 801 W Fireweed Ln. Suite 103, Anchorage, AK 99503

American Diabetes Association®

Diabetes Camp Application – 2011

COUNSELOR/THERAPIST/PSYCHIATRIST QUESTIONNAIRE

To be completed by camper's mental health care provider

Please complete sign, date and return to: American Diabetes Association
Attention: Camp Medical Director
801 W Fireweed Ln. Suite 103 Anchorage, AK 99503

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_____

Parent/Legal Guardian_____

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 self 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.

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.

American Diabetes Association®

Diabetes Camp Application – 2011

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 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 feel free to call

Pam Bell

907-272-1424

American Diabetes Association®

Diabetes Camp Application – 2011

CAMPER'S NAME: _____

Prospective Camper CONSENT FORM

- I hereby apply for admission of my child (name) _____ to the summer Camp for children with diabetes operated by the American Diabetes Association.
- I understand my child shall be subject to the same Camp rules as the other children at Camp.
- I consent to my child receiving any and all medical care, treatment and testing the Camp's health care provider in charge determines is medically necessary, in his or her sole discretion (including without limitation diet, insulin dosage and/or type 2 oral medication and daily blood glucose monitoring). I consent to my child receiving any other medically necessary medical care, treatment, and testing the Camp diabetes care provider in charge may cause to have performed by a licensed health care provider, emergency medical personnel at any facility, clinic or hospital while my child is a Camp participant, including without limitation tuberculin test and x-ray if the test is positive, and blood testing for Hepatitis B and/or HIV antibodies, in the event of an accidental finger prick where there may be possibly contaminated material (such as a syringe needle or lancet). I agree that I am personally responsible for any and all medical charges and expenses resulting from the treatment of my child either on the Camp property or at an off-site facility and that my insurance, if any, shall be the primary insurance plan.
- I further consent to the release of any and all test results to the Public Health Authorities, if such release is required by any law, statute, or regulation.
- I freely give permission to my child's health care providers (including without limitation physicians, physician's assistants, clinical nurse practitioners, R.N.s, R.D.s, certified diabetes educators, therapists, psychologists, etc.) to release any and all information pertaining to my child to the American Diabetes Association, and any third party health care providers or institutions the American Diabetes Association deem medically necessary to treat my child during the Camp session. This consent expires at the end of the camp session or the last day any necessary paperwork arising from the treatment of my child is complete, whichever date is later, and may be revoked at anytime by giving written notice to the American Diabetes Association
- I hereby grant my consent and permission for my child to leave the premises of the camp on occasional trips to nearby points of interest under the supervision of the Camp Staff.
- I understand that while the American Diabetes Association may supply insulin, syringes, monitoring supplies and routine first aid care required at Camp, I shall be primarily responsible for the cost of all other medical treatment of my child, including but not limited to laboratory tests, x-rays, and emergency treatment at a hospital or clinic.
- I understand that ADA is not responsible for any damage, maintenance, repair or replacement of any durable medical equipment (including insulin pumps, continuous glucose monitors, hearing aids) my child may use during camp, and other risks assumed in the use of such devices
- I hereby waive, release and shall indemnify ADA against any and all claims, injury, damages or liability which may arise from my child's use of any durable medical equipment including without limitation misuse, malfunction or medical care in connection with such durable equipment.
- I understand that the purpose of the continuous glucose monitor is to show trends and not to adjust insulin. No alterations in my child's medical plan will be made based on CGM readings/warnings (alarms) without discussion with and approval of camp medical staff directly responsible for my child's care.
- In order to assist in the prompt treatment of my child, I hereby consent to any necessary medical or surgical treatment and testing of my child of an emergency nature and my child receiving off-site medical care at the closest available medical facility. Below my signature, I have listed the policy number for any applicable policies of hospitalization insurance that I carry on this child (including Medical Assistance). I authorize the appropriate representative of the American Diabetes Association to release the information concerning my hospitalization insurance to any provider of medical or surgical services to my child.
- In consideration of the American Diabetes Association allowing my child to attend its summer Camp, I hereby knowingly waive and release the American Diabetes Association, its agents, employees, assigns, volunteers, directors, officers and medical staff, from any and all liability or claim arising out of and in connection with my child's participation in camp for any reason.
- I have read and am aware of and shall abide by the Camper Pick-Up policies.

Please check and initial <u>one</u> of the two following statements:

_____ I do consent to the placement of my child's name, address, phone number and email address in a Camper Directory that is given to each camper.
Initials

_____ I <u>do</u> <u>not</u> <u>consent</u> to the placement of my child's name, address, phone number and email address in a Camper Directory that is given to each camper.
Initials

_____ Further, I have read, and fully understand and I knowingly agree to the terms of this Consent Form.
Initial

_____ _____ _____ _____
Signature of Father/ Mother Date Signature of Legal Guardian Date

The following information is for hospital / immediate care center billing purposes only:

Insurance Company _____Policy Number _____ Group Number _____

Policy Holder Information: Name _____ Birth Date_____ SSN_____

Child's Information: Name _____ Birth Date_____ SSN_____

American Diabetes Association®

Diabetes Camp Application – 2011

AMERICAN DIABETES ASSOCIATION
AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION
HIPAA (Health Insurance Portability and Accountability Act)

Camper Name: _____

Camper's Date of Birth _____

Name of Custodial Parent /Legal Guardian _____

- I hereby authorize the American Diabetes Association (ADA) to release the above named Camper's Personal Health Information (PHI) as described below:

The purpose of this disclosure is to promote the ADA Camp program, publicize the ADA Camp program, and/or fund-raise for the American Diabetes Association:

The PHI to be disclosed is limited to the following:

[ ] Camper photograph or likeness

[ ] Other: (specify_____)

The PHI may be disclosed as part of the American Diabetes Association's marketing efforts, including but not limited to, mailing list development for Camp, a brochure promoting Camp or other educational program, or fundraising events of the American Diabetes Association.

Expiration date: This Authorization shall expire on December 31, 2021.

Right to Revoke: I understand that I have the right to revoke this Authorization at any time by giving ADA written notice of the revocation. I understand that any revocation will not apply to any disclosure that has already been made in reliance upon this authorization.

I understand that I have the right to refuse to sign this Authorization and that my refusal will not affect my child's ability to receive treatment, get payment for treatment, or attend camp.

I understand that I will be given a copy of this signed Authorization.

A copy of this document is valid as an original. The original is not required to be shown.

_____

Custodial Parent's/Legal Guardian's Name (print)

_____/_____

Custodial Parent's/Legal Guardian's Signature / Date

_____

Relationship to Camper

American Diabetes Association®

Diabetes Camp Application – 2011

AUTORIZACIÓN PARA COMPARTIR INFROMACIÓN DE SALUD PERSONAL

HIPAA (Health Insurance Portability and Accountability Act)

Nombre del Participante: _____

Fecha de Nacimiento del Participante_____

Nombre del Padre con la Custodia /Guardián Legal _____

- Autorizo a American Diabetes Association (ADA) a compartir información de salud de la persona anteriormente mencionada según se indica a continuación:

El propósito de compartir la información es para promover o hacer publicidad al programa de campamento de American Diabetes Association, y/o recolectar fondos para American Diabetes Association:

La información de salud que se puede compartir está limitada a:

[ ] Foto del participante u otro documento de identificación

[ ] Otro: (especifique _____)

La información de salud personal puede ser revelada como parte de los esfuerzos de mercadeo del American Diabetes Association, incluyendo, pero no limitada al desarrollo de una lista de contactos, panfletos de promoción del campamento y otro programa educativo, o eventos para recaudar fondos para American Diabetes Association.

Fecha de vencimiento: Esta autorización expira el 31 de diciembre del 2021.

Derecho a Revocar: entiendo que tengo el derecho a revocar esta Autorización en cualquier momento por medio de una notificación escrita a American Diabetes Association. Entiendo que cualquier revocación no aplicará a información que haya sido compartida previamente con relación a esta autorización.

Entiendo que tengo el derecho de negarme a firmar esta Autorización y que hacerlo no tendrá ningún impacto sobre los derechos de mi niño para recibir tratamiento, recibir pagos para tratamientos, o asistir al campamento.

Entiendo que se me dará una copia de la Autorización firmada.

Las copias de este documento son tan válidas como su versión original. No se requiere que se presente el documento original.

_____

Nombre del Padre con la Custodia/ Guardián Legal

(imprima)

_____/_____

Firma del Padre con la Custodia/ Guardián Legal / Fecha

_____

Relación con el Participante

American Diabetes Association®

Diabetes Camp Application – 2011

AMERICAN DIABETES ASSOCIATION CAMP Kushtaka
FINANCIAL ASSISTANCE APPLICATION

This application must be completed in its entirety.
Please attach a copy of your most recent *1040, 1040-A or EZ tax form.*

Mail all information to:
American Diabetes Association
801 W Fireweed Lane Suite 103
Anchorage, AK 99503

Print all information

NAME OF CAMPER: _____

ADDRESS: _____

CITY: _____ STATE:____ZIPCODE_____

DATE DIAGNOSED _____ DATE OF BIRTH _____

NUMBER OF YEARS CHILD HAS ATTENDED CAMP: _____

FATHER'S NAME: _____

ADDRESS (if different than camper) _____

CITY: _____ STATE: _____ZIPCODE_____

PLACE OF EMPLOYMENT: _____

HOME TELEPHONE: _____ WORK TELEPHONE: _____

MOTHER'S NAME: _____

ADDRESS (if different than camper) _____

CITY: _____ STATE: _____ ZIPCODE_____

PLACE OF EMPLOYMENT: _____

HOME TELEPHONE: _____ WORK TELEPHONE: _____

Please attach a copy of your *1040, 1040-A or EZ tax form.*

Are there any extenuating or special circumstances that you would like considered when your application is reviewed?

American Diabetes Association®

Diabetes Camp Application – 2011

List other persons living in your household for whom you provide financial support but do not claim on your taxes.

NAME	RELATIONSHIP TO CAMPER	AGE	STATUS – please circle
_____	_____	_____	Employed Student Other
_____	_____	_____	Employed Student Other
_____	_____	_____	Employed Student Other
_____	_____	_____	Employed Student Other
_____	_____	_____	Employed Student Other

PLEASE NOTE: This application is not a camp registration form to attend camp. This is to request financial assistance only.

HAVE YOU SUBMITTED A CAMP APPLICATION FOR THE ABOVE CAMP?
YES NO

***Note: You must be registered to apply for financial assistance.**

PLEASE STATE THE AMOUNT YOU ARE ABLE TO PAY TOWARDS THE CAMP REGISTRATION FEE: $_____

You will be notified by your American Diabetes Association as to your request for financial assistance and any amount awarded.

Please attach a copy of your most recent *1040, 1040-A or EZ tax form.*

American Diabetes Association®

Diabetes Camp Application – 2011

CAMPER'S NAME: _____

Insulin Regimen

Instructions to Parents: Because it is very common for a child's or teen's insulin regimen (how much insulin they take & how often) to change, please complete this form no sooner than 1 week before camp.

Deadline to Return: < June 26, 2011>
Return To: American Diabetes Association, Camp XXXXX, Address

Insulin /Carbohydrate Regimen for Syringe or Pen Users ONLY

Instructions: Please list the type and amount of insulin given Examples: Breakfast 15N & 3H or 15N plus 1 unit Humalog per 10 grams of carbohydrate	
Breakfast	
Morning Snack	
Lunch	
Afternoon Snack	
Dinner	
Evening Snack	
Correction Factor used for blood sugars above what mg/dl? Example: bs >150	
Insulin Correction Dose: Units given per mg/dl of blood sugar Example: 1 unit Humalog for every 50 points	
Total Daily Carbohydrates:	

For Pump Users ONLY: Pump Basal Rates: Please enter child's rate per hour.

Midnight		8:00am		4:00pm	
1:00am		9:00am		5:00pm	
2:00am		10:00am		6:00pm	
3:00am		11:00am		7:00pm	
4:00am		Noon		8:00pm	
5:00am		1:00pm		9:00pm	
6:00am		2:00pm		10:00pm	
7:00am		3:00pm		11:00pm	

Insulin / Carbohydrate Bolus Rates for Pump Users ONLY

Instructions: Please list the type and amount of insulin given to cover each meal. Example: 1 unit Humalog per 10 grams of carbohydrate	
Breakfast	
Morning Snack	
Lunch	
Afternoon Snack	
Dinner	
Evening Snack	
Correction Factor used for blood sugars above what mg/dl? Example: bs >150	
Insulin Correction Dose: Units given per mg/dl of blood sugar? Example: 1 unit Humalog for every 50 points	
Total Daily Carbohydrates:	

American Diabetes Association®

Diabetes Camp Application – 2011

CAMP REFUND POLICY

The American Diabetes Association strives to control the costs associated with providing camp in order to keep the fee families pay as reasonable as possible. ADA underwrites the cost of every camper by at least 50% of the fee that is charged to families.
In order to provide the camp program, ADA must contract and pay for the procurement of staff, a camp facility and all supplies up to 10 months prior to camp. We must pay all expenses for a guaranteed number of campers regardless of the number that actually attend. Therefore, this policy is to ensure that we can continue to make camp affordable for families, continue providing financial assistance to families who need it, and have time to fill vacancies from the camp waiting list.

Camp Committee unable to place camper in a session:

Refund of Camp Fee & deposit

Camper Cancels after being accepted:

a. Written cancellation received 60 days prior to camp opening day.
Refund of Camp Fee less non-refundable deposit

b. Written cancellation received 59 to 30 days prior to camp opening day.
Refund of 50% of Camp Fee less non-refundable deposit

c. Written cancellation received 29 to15 days prior to camp opening day:
Refund of 25% of Camp Fee less non-refundable deposit

d. Written cancellation received 14 days or less prior to camp opening day:
No refund of Camp Fee or non-refundable deposit.

e. Serious Illness or death in family:
Refund of Camp Fee less non-refundable deposit

Opening Day:

a. Camper not accepted due to condition found by camp physician during camp opening day health screening.
Refund of Camp Fee less non-refundable deposit

b. Camper not showing on opening day.
No Refund of Camp Fee or non-refundable deposit

Early Departure of Individual Camper from Camp:

a. Illness during camp; camp physician recommends camper returns home.
Refund of Camp Fee prorated less non-refundable deposit

American Diabetes Association®

Diabetes Camp Application – 2011

b. Illness during camp; camp physician recommends camper can remain in camp, but parent elects to withdraw camper.
No Refund of Camp Fee or non-refundable deposit

c. Serious Illness or death in family, camper removed at parent's request.
Refund of Camp Fee prorated less non-refundable deposit

d. Camper elects to leave camp early (camper homesick; camper wanting to return home for various reasons).
No Refund of Camp Fee or non-refundable deposit

e. Camper sent home for reasons determined appropriate for protection of said camper, other campers or staff.
No Refund of Camp Fee or non-refundable deposit

Early Closure of Camp because of Shortened Session due to Fire, Epidemic, or Natural Disaster:

a. During the first half of camper session.
One-half of camp fee paid will be refunded less non-refundable deposit

b. During the last half of camper session.
No Refunds will be made

c. Camp closed prior to session due to above.
Refund of camp fee less non-refundable deposit

Late arrival or camper absence during camp session:

No Refund of Camp Fee or non-refundable deposit