



ADA Diabetes Camp Application –2009



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.

I agree that all decisions about my insulin and my food will be discussed with either one of the doctors or one of the nurses helping to run the camp.

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. If I do, I may not be allowed to attend Camp.

Camper Signature

Parent/Guardian Signature

Date

Date

Return to: American Diabetes Association, Attn: Camp Korelitz, 644 Linn St. ste 304, Cincinnati, Ohio 45203



ADA Diabetes Camp Application –2009



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 Camp Korelitz 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

Insulin /Carbohydrate Regimen for Basal and Bolus Therapy

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: _____

Basal Insulin (i.e.- Lantus) Dose _____ Time _____



ADA Diabetes Camp Application –2009



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:
American Diabetes Association
c/o Camp Korelitz
644 Linn St. ste 304
Cincinnati, Ohio 45203



ADA Diabetes Camp Application –2009



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
644 Linn St. Ste 304
Cincinnati, Ohio 45203

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.



ADA Diabetes Camp Application –2009



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 **Erin Crosby** at (513) 759-9330 ext. 6662.



ADA Diabetes Camp Application –2009



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 one 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
Initials each camper.

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

_____ 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 _____



ADA Diabetes Camp Application –2009



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, 2019.

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



ADA Diabetes Camp Application –2009



CAMPER'S NAME: _____

METER INFORMATION

Brand & Model Name of Meter Used: _____

INSULIN INFORMATION-

IF CAMPER USES SYRINGES OR INSULIN PEN TO DELIVER INSULIN COMPLETE INJECTION SECTION ONLY. IF CAMPER USES INSULIN PUMP TO DELIVER INSULIN COMPLETE PUMP SECTION ONLY.

INSULIN INFORMATION -INJECTIONS (USES INSULIN PEN OR INJECTIONS ONLY)

Brand, Types & Method used: **Circle all that apply.** For method, circle vial or type of pen used.

Brand: Lilly		Brand: Novo-Nordisk		Brand: Sanofi-Aventis	
Type	Method	Type	Method	Type	Method
Humalog	Vial KwikPen HumaPen Luxura HD HumaPen Memoir Humalog Prefill	Novolog	FlexPen NovoPen Jr NovoPen 3	Lantus	Vial SoloStar OptiClik
Brand: Lilly		Brand: Novo Nordisk		Brand: Sanofi-Aventis	
Type	Method	Type	Method	Type	Method
Humulin R	Vial	Novolin R	Vial	Apidra	Vial OptiClik
Humulin N	Vial	Novolin N	Vial		
Humulin Mix 50/50	Vial	Novolin 70/30 (N/R)	Vial		
Humulin 50/50	Vial	Novolog Mix 70/30	Vial FlexPen		
Humulin 70/30 (N/R)	Vial KwikPen	Levemir	Vial FlexPen		
Humalog Mix 75/25	Vial KwikPen	ReliOn	Vial		

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

INSULIN SYRINGES AND PEN NEEDLES- CIRCLE THE TYPE(S) OF SYRINGE OR PEN NEEDLE USED

Insulin Syringe Brand, Size and Needle Length

Brand: BD

- BD UltraFine Syringe 30g 3/10cc (30 units)
- BD UltraFine II Short Needle Syringe 3/10 cc 31g (30 units)
- BD Ultra-Fine II Short Needle Syringe Half-Unit Scale 3/10 cc (30 units)
- BD Ultra-Fine IV Syringe 28g 3/10 (30 units)
- BD UltraFine Syringe 30g 1/2cc (50 units)
- BD Ultra Fine II Short Needle Syringe 1/2 cc 31g (50 units)
- BD Ultra-Fine IV Syringe 28g 1/2 cc (50 units)

Brand :Precision SureDose

- 3/10 cc (30 units)
- 1/2 cc (50 units)
- 1 cc (100 units)



ADA Diabetes Camp Application –2009



BD UltraFine Syringe 30g 1cc (100 units)	
BD UltraFine II Short Needle Syringe 1cc 31g (100 units)	
BD Ultra-Fine IV Syringe 28g 1 cc (100 units)	

Other Syringe Brand:	Syringe Size:	Needle Length:
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Insulin Pen Needle Brand, and Needle Length	
Brand: BD BD Ultra-Fine Mini (5mm) BD Ultra-Fine Short (8mm) BD Ultra-Fine Original (12.7mm)	Novo-Nordisk NovoFine 32 g Novofine 30 g

Does child use a CGM (Continuous Glucose Monitoring) <input type="checkbox"/> Yes <input type="checkbox"/> No Do you plan for your child to use the CGM at camp? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list Brand:
Is specific meter required for calibration of CGM ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Brand & Model Name of Blood Glucose Meter Used:	

INSULIN INFORMATION- PUMPS (PUMPERS ONLY)

CIRCLE INSULIN USED IN PUMP:

NOVOLOG
 HUMALOG
 APIDRA

Circle Pump Brand and Model Name			
Medtronic	Animas	Cozmo Deltec	Omnipod
Paradigm Real Time 522	2020	1700	
Paradigm Real Time 722	Ping	1800	
Paradigm 515	1200		
Paradigm 715	1250		
Paradigm 511			
Paradigm 512			
Paradigm 712			
508			

Start Date: Year: _____ Month: _____	Pump Serial Number: _____
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Circle Pump Infusion Set and Tubing		
Brand: Medtronic	Brand: Animas	Brand: Deltec
Quickset 6mm	Comfort 17 mm	Cleo 90 6mm
Quickset 9 mm	Comfort Short 13 mm	Cleo 90 9 mm
Silhouette 13 mm	Inset 30 (13 mm)	
Silhouette 17 mm	Inset 90 (6mm)	
Sure-T	Inset 90 (9mm)	

Tubing Length _____

CAMPER'S NAME: _____



ADA Diabetes Camp Application –2009



CAMPER'S NAME: _____

Does your camper (using a pump) also use injections of another kind of insulin? If yes, answer below:

Insulin Brand and Type	
Delivery Method	Vial Syringe Brand, Type and size _____
	Pen (please list name) _____ Pen needle Brand, Type and size _____



ADA Diabetes Camp Application –2009



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, the medical staff at camp will verify insulin doses at camp check-in.

Deadline to Return: July 1, 2009

Return To: American Diabetes Association, Camp Korelitz, 644 Linn St. Ste 304, Cincinnati, Ohio 45203

Insulin /Carbohydrate Regimen for Syringe or Pen 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:	

Basal Insulin (i.e.- Lantus) Dose _____ Time _____

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	
Bedtime	
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:	



ADA Diabetes Camp Application –2009



Insulin Regimen for Split/Mixed Therapy (i.e.- N/R) ONLY

Instructions: Please list the type and amount of insulin given

Example: Breakfast 15 N and 3 R or

Breakfast 15 N plus 1 unit Humalog for every 10 grams carbohydrates

Meal	Insulin Dose	Amount of Carbohydrates
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Dinner		
Bedtime		



ADA Diabetes Camp Application –2009 **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 to 15 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
- 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



ADA Diabetes Camp Application –2009

- 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 fees 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