



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.

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: **ADA/ Camp AZDA**
8125 N. 23rd Avenue, Ste. 222
Phoenix, AZ 85021-4961



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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 AZDA** will be greatly appreciated. The Due Date for this form is May 15th. **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 _____	

PLEASE CIRCLE ALL THAT APPLY:

- | | |
|------------------------|---|
| Lilly (Humulin) | Humalog, Humulin N, Humulin R, Humulin 70/30, Humulin 50/50, Humalog Mix 75/25, Humalog Mix 50/50 |
| Novo-Nordisk (Novolin) | Novolog, Novolin N, Novolin R, Novolin 70/30, Novolog Mix 70/30, Levemir, ReliOn |
| Sanofi-Aventis | Lantus, Apidra |



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Other Insulin (Specify) _____

Pen _____

Pump: Please 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: _____

Please return by May 15th.

Mail Form To: **ADA/ Camp AZDA**
8125 N. 23rd Avenue, Ste. 222
Phoenix, AZ 85021-4961

OR Fax to: Camp AZDA, 602-995-1344



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COUNSELOR/THERAPIST/PSYCHIATRIST FORM

To be completed by health professional listed above

To Parent: **IF** your child has been in counseling within the past year, please have the Counselor/Therapist/ Psychiatrist/ Psychologist complete and return this Questionnaire

Please complete sign, date and return to: **American Diabetes Association**
Attention: **Camp Medical Director**
8125 N. 23rd Avenue, Ste. 222
Phoenix, AZ 85021-4961
Fax: 602-995-1344

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.

*****OVER*****



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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 of Health Provider

Date

Address: _____

City State Zip

Thank you for your cooperation. If you have any questions or comments, please feel free to call **The American Diabetes Association at 602-861-4731 ext. 7094.**



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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 each camper.
Initials

_____ 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 each camper.
Initials

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

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 _____

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Phoenix, AZ 85021-4961



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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:

Check all to which you agree.

The PHI to be disclosed is limited to the following:

Camper photograph or likeness

I would like my child and I to receive a username and password for access to ADA's Camp Web pages for ongoing communication with Camp staff and campers.

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

Return to: ADA/ Camp AZDA
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AUTORIZACIÓN PARA COMPARTIR INFORMACIÓN 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:

Marque todas con las que está de acuerdo:

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

Foto del participante u otro documento de identificación

Quisiera que mi hijo/hija reciba un nombre de usuario y contraseña para tener acceso a las páginas Web de la ADA para tener constante comunicación con el personal y participantes del campamento.

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 2019.

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

Envias esta forma a: ADA/ Camp AZDA
8125 N. 23rd Avenue, Ste. 222
Phoenix, AZ 85021-4961