



2009 Camp Application



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.
- I will follow the camp's dress code which is

Girls:

- no clothing advertising alcohol or tobacco
- no spaghetti straps
- no two piece bathing suits
- no short shorts or ultra low-rise jeans
- no short t-shirts revealing the belly

Boys:

- no boxers showing above jeans or shorts.
- no clothing advertising alcohol or tobacco

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



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Camper Diabetes Medical Form- Page 1 of 2

To be completed by camper's DIABETES health care provider

Dear Doctor:

Your cooperation in supplying the following information about an applicant for **American Diabetes Association's Camp Colorado** 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 _____	



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Camper Diabetes Medical Form- Page 2 of 2

To be completed by camper's DIABETES health care provider

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 Regular NPH, 70/30

Sanofi-Aventis Lantus, Apidra

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: _____

Mail Form To: American Diabetes Association-2480 W. 26th Avenue, Suite 120 B, Denver, CO 80211

Fax: 720-855-1302



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Camper Health Evaluation From- Page 1 of 2

To be completed by camper's PRIMARY health care provider

PARENTS: Please complete this information **BEFORE** submitting to Physician.

Name of camper: _____ Gender: M F Date of Birth: ___/___/___

Parent or Guardian: _____ Phone: _____

Home Address: _____ City: _____ St: _____ Zip: _____

Date of Current Exam: _____

Date of last physical exam: _____

HEALTH HISTORY (Please check all that apply, giving approximate dates if applicable)

Condition	X	Condition	X	Allergies	X
Frequent Ear Infections		Mononucleosis		Hay Fever	
Heart Defect/Disease		Convulsions		Ivy Poisoning	
Chicken Pox		Asthma		Insect Stings	
Mumps		Bleeding/Clotting Disorders		Penicillin	
Measles		German Measles		Other drugs	

Has camper had any serious injuries or operations? YES NO If YES, please list:

Does camper have a disability or chronic/reoccurring illness? YES NO If YES, please list:

Does camper have any dietary restrictions? YES NO If YES, please list:

Do you carry family medical/hospital insurance (circle one)? YES NO

If YES, indicate: Carrier: _____ Policy or Group Number: _____

IMMUNIZATION HISTORY (Fill in the information below or attach a copy of the immunization record)

Vaccines	Year of Basic Immunization	Year of Last Booster
DPT or TD*	1	1
	2	2
	3	
Oral Polio (Sabin)* TOPV OR Injectable Polio (Salk)		
MMR		
Hep B		
HiB		
Varacella		
Pneumococcal		
Influenza		
Other (List):		
TB (most recent)		



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Health Evaluation Form – Page 2 of 2

To be completed by camper's PRIMARY health care provider

I have examined the above camp applicant: _____

In my opinion, _____'s condition does ____/does not ____ preclude his/her participation in an active camp program.

The applicant is under the care of a physician for the following condition(s):

Current treatment (include current medications)

Does the applicant have epilepsy? YES NO Does the applicant have diabetes? YES NO

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

Any treatment to be continued at camp:

Any medication to be administered at camp (specific dosages):

Any medically prescribed meal plan or dietary restrictions:

Any allergies (food, drugs, plants & insects, etc):

Physician's name (please print)

Physician's Signature

Date

Address: _____

Phone: () _____

Form completed by*: _____

*(Initial if completed by nurse or physician's assistant)

**SEND or FAX Form To: American Diabetes Association, ATTN: Camp
2480 W. 26th Avenue
Suite 120 B
Denver, CO 80211)
FAX: 720-855-1302**



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COUNSELOR/THERAPIST/PSYCHIATRIST QUESTIONNAIRE- Page 1 of 2

To be completed by camper's MENTAL health care provider

Please complete sign, date and return to: American Diabetes Association
Attention: Perri Dombroski
2480 W. 26th Avenue
Suite 120 B
Denver, CO 80211
Fax: 720-855-1302

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.
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.



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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 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 _____



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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



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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:

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 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



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RELEASE AND APPLICATION FOR EXEMPTION FROM IMMUNIZATION REQUIREMENTS

It is respectfully requested that _____ be exempted upon religious or other beliefs from the physical examination and all immunization requirements required for attendance at the American Diabetes Association Camp Colorado. To the best of my knowledge and belief, s/he is and has been in normal good health and is free from all communicable or contagious diseases.

Should the above named camper (from here in referred to as "camper" unless otherwise noted) manifest any condition where there appears to be reasonable grounds for suspecting the presence of a communicable or contagious disease, I agree that a physical examination may be performed. Also, I agree that if any such disease is found, "camper" will comply with the regular quarantine or isolation procedures of the camp and of the community.

It is further understood that, should an emergency arise, I will be notified immediately. However, in the event that we cannot be located immediately, the authorities of Camp Colorado may take such temporary measures as they deem necessary.

I release and forever discharge the American Diabetes Association, Eagle Lake and each and every one of their officers, directors, partners, employees, agents, insurers, successors in interest, attorneys, or any other person or persons associated with any or all of them or any variation in the name of any or all of them who might be liable (the "Released Parties") from all causes of action, suits, claims, demands, or any other damages or costs associated with actions taken by the Released Parties relative to the health, sickness, and treatment of _____.

(Camper's name)

I further understand and acknowledge that I make this release in full accord and satisfaction of and in compromise of any current or future disputed or alleged claims or causes of action relative to the health, sickness, and treatment of "camper" against the Released Parties.

I represent and acknowledge that I have read and understand this agreement and release and warrant that all statements made herein are true to the best of my knowledge. I further warrant and acknowledge that I am of legal age, legally competent to execute this agreement and release, and accept full responsibility therefore.

Date _____

Signature _____

Printed _____

Address _____

City _____ State _____ Zip _____



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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 and camper returns home.
No Refund of Camp Fee or non-refundable deposit
- b. Serious Illness or death in family, camper removed at parent's request.
No Refund of Camp Fee or non-refundable deposit



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- c. 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
- d. Camper sent home for reasons determined appropriate for protection of 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