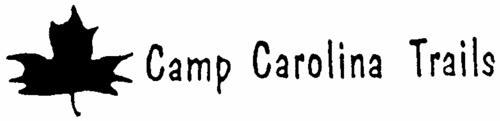


222 South Church St., Suite 336M
Charlotte, NC 28202

A program of the American Diabetes Association

Dear Camp Carolina Trails Applicant:

Thank you for completing the online application for Camp Carolina Trails. The 2009 session of Camp Carolina Trails will be held June 14-20 at YMCA Camp Hanes in King, North Carolina. We are looking forward to a great week of fun and adventure.

Campers must be entering the 4th through the 11th grade in Fall 2009 to be accepted into Camp Carolina Trails. Every camper must submit each of the following forms **IN ADDITION TO THE ONLINE APPLICATION** before they can be accepted into Camp Carolina Trails:

Medical Information Form	Parents and doctor complete
Consent and Waiver Form	Parents complete
Self Care Questionnaire	Camper and parents complete
Dietary Questionnaire	Camper and parents complete
HIPPA Form	Parents complete
Behavior Contract	Camper and parents complete

ALL SIX FORMS must be completed and returned to our office, along with a $100 registration fee (if it wasn't paid online), before your application will be reviewed for acceptance into camp. The registration fee will be refunded ONLY according to the guidelines contained in this packet. The total fee for camp this year is $600. A limited number of partial camperships are available to youth who demonstrate need. The amount of the campership is determined by the family's ability to pay. For a campership application, call the American Diabetes Association Office at 1-888-342-2383, Ext 3262.

A baseline tuberculin test is recommended, but not required. Campers should review with their physician who should note the date and the result on the Medical Information Form and update the tuberculin test if needed.

Each camper must have received a tetanus vaccine since June 13, 1999 (indicate date of last vaccine on the Medical Information Form). This **must be** on the health form.

The deadline for submission of all forms and the $100 registration fee is May 29, 2009; however, the camp fills quickly so you are encouraged to return the completed application forms as quickly as possible**. Please be sure that all forms are filled out completely, as any missing information will delay or prevent acceptance into camp.**

Return completed application forms to:

Camp Carolina Trails
American Diabetes Association
222 South Church Street, Suite 336M
Charlotte, NC 28202

Information regarding acceptance will be mailed on a rolling basis. You will be notified by mail of acceptance to Camp Carolina Trails within three weeks of our receipt of your completed camper application. The remaining portion of the camp fee ($500) will be due by **June 5, 2009**. If you have questions, you may call the American Diabetes Association Office at 1-888-342-2383, Ext. 3262. We look forward to receiving your completed application soon!

Sincerely,
Camp Carolina Trails Committee

Camp Carolina Trails Self Care Questionnaire- 2009

First Name_______________________ **Last**________________________**DOB**_____________ **Age**______

I. ORAL MEDICATIONS

Name:___________________________ Dose: __________ Time(s)________________
Name:___________________________ Dose: __________ Time(s)________________
Name:___________________________ Dose: __________ Time(s)________________
Name:___________________________ Dose: __________ Time(s)________________

II. INJECTIONS TIME / UNITS / INSULIN TYPE

________time / __________units /_______ insulin type
________time/ __________units /_______insulin type
________time/ __________units /_______insulin type
________time/ __________units /________insulin type

Sliding Scale

_____units if _______ _____ units if ______
_____units if _______ _____ units if ______
_____units if _______ _____ units if ______
______units if _______ _____ units if ______

INSULIN PUMP BASAL RATE

from _________ to _________ ________units
from _________ to _________ ________units
from _________ to _________ ________ units
from _________ to _________ ________ units

Bolus dose(s)_________units per_______grams carbs

Correction Sensitivity: 1 unit lowers glucose ________ mg/d

Correction Target :___________________

III. DOES THE CAMPER

Give own injections? ***Yes No*** Draw up insulin? ***Yes No*** Check blood sugar? ***Yes No***

Wear a Medi–Alert? ***Yes No*** Carry sugar? ***Yes No*** Rotate pump site? *Yes No*

Change infusion set? *Yes No* Change Cartridge and prime tubing? *Yes No*

How often do you check--Urine ketones _________ Blood glucose _______/day

Hypoglycemia - Do you know when you have a low blood sugar *Yes No*
Symptoms____

Have you ever had a bad low-- required help from someone to treat a low, lost consciousness or needed Glucagon?

Yes No Please describe____

What is your target glucose range? __________-___________ How often do you achieve it? ________________

Are there any unusual circumstances that could cause the camper concern (i.e. divorce, illness etc.?)____

Person completing form ___________Reviewed by Parent / Guardian (signature)___________________________

Office use only

Cabin __________

Table __________

RD __________

Dietary Questionnaire 2009

Camper's name____________________________ Nickname__________________________

Primary Parent/Guardian Home Phone _________________Email______________________

At meals, does your child **need help** with:

	No help needed	**Needs help**
Counting the number of carbs eaten	☐	☐
Giving the right amount of insulin	☐	☐

We need an idea of how much your child usually eats. My child's diet can be described as:

______ Insulin is given based on how many carbs are eaten: _____Units Insulin to ____grams carbohydrate

Please indicate the **usual range** of carbs on **Pattern A** below (example: 25-50 gms)

______ Consistent carbs are eaten. Please complete **Pattern A** below

______ Other. Please describe _________________________________. Please complete **Pattern B** below.

Pattern A: Carbohydrate counting

		Do not write in these columns	
Meal	**Carbohydrates**	**Camp**	**Home**
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			

Pattern B: Typical Intake

Estimate portions in measuring cups or level tablespoons. Please enter actual foods rather than "meat", "vegetable"...
Be as exact as you can. Include condiments, sauces, margarine/butter.

Amount	**Food**	**Amount**	**Food**
Breakfast		**Morning Snack**	
Lunch		**Afternoon Snack**	
Dinner		**Bedtime Snack**	

How many hours per day does your child spend in:

VIGOROUS activity (basketball, swimming, bicycling, running) _____ **hours per day**

MODERATE activity (walking, playing outside with friends, shopping) _____ **hours per day**

Camp Carolina Trails

HEALTH EVALUATION AND INFORMATION FORM

DEADLINE: This form should be returned with camp application and must be received before an applicant can be considered for acceptance to camp. The completed application including medical form **MUST be received by May 29, 2009.**

TO BE COMPLETED BY PARENT OR GUARDIAN

PERSONAL INFORMATION (CAMPER)

First Name____________________________________ Last Name___________________________________

Phone Number___________________________________Date of Birth____________________

Problems with insulin administration (i.e. problems with pump site)?___________________________________
____

If you have a continuous glucose sensor, will you be using it at camp? ________________________________

HEALTH HISTORY/IMMUNIZATION RECORD (give dates of disease or year immunization completed; this record MUST be completed accurately and completely; **date of last tetanus immunization must be later than 6/13/99)**;

All spaces must be filled in. We must have dates for immunizations and information regarding these illnesses and drug allergies. If not applicable, please fill in with N/A

Ear Infections		Insect Sting Allergy		Diphtheria/Pertussis/Tetanus (DPT)	
Rheumatic Fever		Ivy Poisoning, etc.		Tetanus/Diphtheria (TD)	
Convulsions		Asthma		Polio (Salk or Sabin)	
Behavior Concern		Drug Allergies:		MMR 1 (Measles, Mumps, Rubella)	
Hay Fever		Penicillin		MMR 2	
Chicken Pox		Other Drugs		Hepatitis B	

Operations or serious injuries (include dates)____

NOTE: You will be notified, as soon as reasonably possible, if your child is taken out of camp for medical care (emergency room or the urgent care facility).

I verify that the above information is complete and correct____

Signature of Parent or Guardian and Date

This form MUST be filled out completely and must have the physician's signature. Without these things, the child cannot be considered as an applicant.

TO BE COMPLETED BY LICENSED PHYSICIAN

HEALTH EVALUATION FOR (NAME) ____________________________________ **Date of Examination**________________

This examination should be performed within the 12 months prior to June 13, 2009. **Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.**
Ht___________ Wt___________ BP___________ HbA_1C (Date)___________ Result_________________________

A baseline tuberculin skin test (TST) is **recommended and voluntary**. Update if there have been any risks for TB exposure (such as living in an endemic country, exposure to a person with TB).
Tuberculin Test- Date_______________ Result_______________

CODE: ___/___ **Satisfactory** ___X___ **Not Satisfactory** ___0___ **Not Examined**

Eyes	Lungs	Allergies - Please Specify
Glasses	Abdomen	
Ears	Hernia	
Nose	Extremities	General Appraisal
Throat	Posture (Spine)	
Teeth	Skin	
Heart	Other	

Please explain any __X__ above :____
____
____

Does this patient have any physical disabilities other than diabetes? ______ Yes ______ No
If yes, please specify____

What medications (other than insulin) does the camper use? ____

Are there factors which would limit this patient's ability to benefit from camp? ___________________________________
____

Do you have special instructions or restrictions while at camp? Please describe fully. ______________________________
____

Does this patient have any behavioral problems?____
Has this patient been hospitalized in the last 12 months?______; If so, explain_________________________________
____

Consider this patient's other resources for recreation, peer relationships, diabetes teaching, etc. Which of the following do you feel pertains?
___Camp is very urgently needed ___ Camp is urgently needed ___ Camp would be helpful but isn't urgently needed

I have examined the person herein described on the date indicated above and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities except as noted above.

______________________________	______________________________
Name of Examining Physician (please print)	Examining Physician's Signature
______________________________	______________________________
Address	Telephone
______________________________	______________________________
City, State, Zip	Date

Prospective Camper

CAMP CAROLINA TRAILS 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

Check Initials a Camper Directory that is given to each camper.

_____ _______ I **do not** consent to the placement of my child's name, address, phone number and email Check

Initials address in a Camper Directory that is given to each camper.

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

Initial

X_______________________________ ___________ __________________________ __________

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

PLEASE SEE BACK FOR ADDITIONAL VOYAGER AND NAVIGATOR CONSENT FORM

TO BE COMPLETED BY VOYAGERS ONLY (AGES 14-15, ENTERING 9TH or 10th GRADE)

ASSUMPTION OF RISK AND CONSENT

I ____, fully understand that my participation in rock climbing or the low/high ropes course under the direction of Camp Hanes staff could result in accidental injury or death. Also, my participation requires that I be of good physical condition and I do hereby accept all responsibility for my own physical well-being.

Being fully aware of the degree of risk and injury to myself, I hereby release the American Diabetes Association of any liability resulting from any accident or injury incurred by me while participating in this activity.

____ _________________________________

Signature of Participant Date

____ _________________________________

Signature of Parent or Guardian Date

TO BE COMPLETED BY NAVIGATORS ONLY (AGES 16-17, ENTERING 11TH GRADE)

ASSUMPTION OF RISK AND CONSENT

I, ____, fully understand that my participation in river canoeing, inner-tubing and/or kayaking under the direction of Camp Carolina Trails staff and my participation in rock climbing or the low/high ropes course under the direction of Camp Hanes staff could result in accidental injury or death. Also, my participation requires that I be of good physical condition and I do hereby accept all responsibility for my own physical well-being.

Being fully aware of the degree of risk and injury to myself, I hereby release the American Diabetes Association of any liability resulting from any accident or injury incurred by me while participating in these activities.

_______________________________________ _________________________________

Signature of Participant Date

_______________________________________ _________________________________

Signature of Parent or Guardian Date

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.

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.

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, 2018.
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

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:

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.

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 2018.
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

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 language.

I will not engage in any sexual contact.

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.

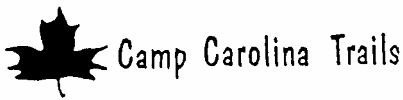
I have read and understand the rules and will help enforce them. In addition, I have read and explained the camp rules to my child and believe that he/she understands them. I agree to pick my child up from camp if he/she breaks this contract.

______________________________ ______________________________

Camper Signature Parent/Guardian Signature

______________________ ______________________

Date Date



CAMPERSHIP APPLICATION

This form should be completed by the parent or guardian and returned directly to:

American Diabetes Association
222 South Church Street, Suite 336M
Charlotte, NC 28202

Deadline for campership application is: ***ASAP***

Name of Camper____ Date of Birth________________ Sex___________

Address____ County______________________

City____ State________________ Zip______________

The number of camperships is limited and more information is needed so that they can be given to those who need them most. Please fill in this form and return it as soon as possible. Camperships will be awarded by the Camp Carolina Trails Campership Committee. Every camper is *strongly* urged to pay some amount toward the cost of camp. **Prior campership awards do NOT guarantee a campership award for Camp Carolina Trails 2009.**

I can pay $____________ toward the $600 fee for camp. I understand that this amount is due 10 days after my child is accepted unless a payment schedule is arranged.

Father's Name____ Occupation________________________

Employer's Name____ Telephone (______)_________________

Employer's Address____

Mother's Name____ Occupation________________________

Employer's Name____ Telephone (______)_________________

Employer's Address____

Income: List the amount of income for each parent. Income is subject to verification by employer.

Father's Income: $___________________ per week / month (circle one)

Mother's Income: $___________________ per week / month (circle one)

Please attach a copy of your 1040 tax form. We will not be able to accept any other form of income verification.

Other Income (list sources and amounts)____

____

List any unusual expenses you are having and any other information you would like considered____

____

____

Names and ages of children living in the home besides camper____

____

Sometimes the ADA can raise money for camperships through civic and church groups and through interested people in the camper's community. To raise money it may be helpful to use the camper's name. May your child's name be used?

Yes_________ No___________

The above information I have given is complete and accurate.

____ ____

Signature of Parent or Guardian Date