ADA Diabetes Camp Application –2009

Dear Parents and Prospective Camper:

Thank you for completing step one of your online registration process. This is our second year launching our nationwide online application process and we appreciate your patience as we get the new year rolling. We hope this online process will make filling out camper applications quicker and easier.

As instructed, you MUST print and fill out the additional attached camper forms that follow this letter:

- Medical Form/Health Evaluation – completed & signed by diabetes health care provider & returned in a signed/sealed envelope
- Consent Form – signed by parent
- HIPAA Form – signed by parent
- Immunization Form/ Insulin Regimen Form- completed by parent
- Refund Policy – for your information
- Financial Assistance Form – if needed

Please make a copy of your supplemental forms before submitting and have your physician make a copy of his/her form. Only complete applications, received with the non-refundable deposit will be submitted to members of the ADA camp committee for review. Incomplete applications will be returned and will not enter the processing system until resubmitted as a complete application. Missing forms, missing information (i.e. immunization information or insurance information) will cause your application to be returned to you.

Once you have completed and mailed the supplemental forms to the ADA office (address below) you may continue filling out the online application.

Priority System: Applications are processed and reviewed on a *first come, first serve* basis*. Once application forms have been reviewed by the members of the ADA Camp Committee, confirmations will be made on a *first come, first serve* basis. It is critical that you complete all required forms and submit them as soon as possible. The information you provide allows us to adequately prepare for the best week of your child's summer. Once accepted, you will receive a "confirmation packet".

***First come, first serve is defined as: the date the original forms are returned to the office, complete and ready to process.**

Once all camper slots are filled, children will be placed on a waiting list. This waiting list is important so that we can fill camp slots at the last minute. While many of the children on our waiting list do find a space at camp, we cannot guarantee an opening. You can increase your child's likelihood of attending camp if the application form and all accompanying materials are submitted as soon as possible. If you are interested in attending one of our camps, please complete the enclosed forms.

Payments: If you did not pay both the non-refundable deposit and the remaining camper fee online, full payment must be received before the start of camp. If you are in need of financial assistance, you must complete and return the financial assistance form attached with this letter. You will be notified by Sue Apsey, Camp Director, if/when financial assistance is awarded. Please contact her, 312-346-1805, ext. 6567, with any questions you may have regarding your financial assistance application.

ADA Diabetes Camp Application –2009

Our camps are organized and operated by the American Diabetes Association (ADA) in conjunction with leading medical and camping professionals in your local community.

Both our day camps and residential camps are accredited by the American Camp Association. This accreditation means that the ADA can provide a safe, medically supervised camping experience for children with diabetes. It is our hope that each child who attends camp will grow as an individual through the ideas and experiences shared through this camping experience.

Opportunities to learn are offered in informal settings. In years past, campers have described their experience at camp as educational and fun! While diabetes camp is not a clinic in the woods, our medical team provides round the clock care at camp for your child with safety as our primary concern. The medical team is fully capable of addressing a child's blood sugar fluctuations brought on by changes in daily routine and environment. These fluctuations are likely and expected, and should in no way hinder a child from fully participating in the camping experience.

For questions, please contact Jackie Wisz at 312-346-1805 or 1-888-DIABETES, ext. 6581 or Jwisz@diabetes.org.

Mail ALL Forms To:

Attn: Jackie Wisz
American Diabetes Association
30 N. Michigan, Suite 2015
Chicago, IL. 60602

Sincerely,

American Diabetes Association Camps

ADA Diabetes Camp Application –2009

PHYSICIAN'S FORM

CAMPER'S NAME _________________________________ **DATE** ____/____/____

Please check the appropriate camp sponsored by the American Diabetes Association, Northern Illinois Area.
[ ] Camp Discovery (Glen Ellyn) [ ] Camp Confidence (Des Plaines) [ ] Camp Can-Do (Palos Park)
[ ] Triangle D Camp [ ] Teen Adventure Camp

---

1. General Health:

Significant illness or physical disability: ____

____

Medication(s) other than insulin (with dose & for what?):________________________________

____

____

Allergies (food, medicine, animals, etc.) if asthma, please indicate severity: ________________

____

Physical Limitations: ____

Menarche for girls: Age: _________

Non-diabetes hospitalizations (date/diagnosis): __________________________________

____

2. Has your patient had exposure to any blood transmissible diseases?

Yes [ ] No [ ] If so, of what nature? ____________________________________

3. Most Recent Exam:

Date: ________ Height _______ Weight _________ B/P: ________ HR: ________
Skin: ____
HEENT: ____
Thorax: ____
Abdomen/Genitals: ____
Neurological: ____

4. Diabetes Management:

Age of diabetes onset: ______ Year of diagnosis: _______________

Hospitalizations (for diabetes) date & diagnosis: ___________________________________

____

Most recent HbA1c level**:** ****_**This is mandatory**_ ***and must have been within the last three months*****
Date: ____________ Result: __________________ Normal Range for Lab: ___________
Current goals of diabetes management: ____

____

What meter does the patient use? _________________________________ #Tests/day _________________

Is child/teen on an insulin pump? Brand ______________________________________

How long has child/teen been using the pump? List number of years, months or start date: _______________

Do you anticipate child/teen going on a pump before camp? [ ] Yes [ ] No

NOTE: If you anticipate your patient will be placed on a pump prior to the start of camp; please be advised that the camp medical staff requires that the youth be on a pump, using insulin, AT LEAST THREE WEEKS PRIOR TO CAMP.

Is camper on a continuous glucose monitoring system? [ ] Yes [ ] No

If yes, what system?____

ADA Diabetes Camp Application –2009

Insulin Types and Dosage: Please list the type and amount of insulin given

Home Insulin Regimen:

Please Indicate Sliding Scale or Bolus				
Type	Breakfast	Lunch	Dinner	Bedtime

Pump Basal:

Rate	Time	Rate	Time

Correction Factor: ______________________________

Insulin/Carb Ratio:

Breakfast	Lunch	Dinner	Bedtime

Does the patient or family adjust insulin at home?
[ ] Yes [ ] No
Indicate what the sliding scale is, if used:
____

Indicate target blood sugar range: ________________________________

Circle Insulin BRAND: Lilly NovoNordisk Sanofi-Aventis Pen: [ ] Yes [ ] No

Circle TYPE: Humalog Novolog Regular NPH Levimir ReliOn Lantus Apidra Other: ___________________

Meal Plan: Number of meals per day____ Number of snacks per day____ **Insulin for Snacks? ( ) Yes ( ) No**
Please mark what system is used: Carbohydrate Counting [ ] Exchange System [ ]

Carbohydrate Counting is used and taught at camp. Each camper is given an individual meal plan based on the camper's home meal plan and the camp activity program.

5. Emotional Status:

It is imperative that the camp medical staff be aware of any family emotional problems which may affect your patient's health care at camp.

Has your patient and/or family been in counseling in the last year? Yes [ ] No [ ]

Has your patient been referred for counseling in the last year? Yes [ ] No [ ]

If so, what is the nature of the problem? ____

6. Do you have any specific suggestions as to the care of your patient while at camp?

____

____

**For Overnight Camp:

Is there any concern about your patient in a remote setting? Yes [ ] No [ ]

If yes, please explain. ____
____

During your patient's stay at camp, he or she will be monitored as closely as conditions permit. Any necessary alterations in your patient's diabetes management will be made under the supervision of an attending physician.

**For Day Camp:

During your patient's stay at camp, he or 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 nurses and dietitians, under the supervision of a physician member of the Camp Committee of the American Diabetes Association, Northern Illinois Area.

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Signed: ___________________________________ Date:________________________________

___________________________________, M.D./D.O. **Email:**__________________________
(please print/type) **MD or Office**

Address: _____________________________ **Phone:** (____)_________________________________

_____________________________ **Emergency Phone (____)**________________________

Please return in a sealed and signed envelope to: PATIENT'S PARENT as soon as possible. Delay in returning this form may jeopardize your patient's application to camp. Rev. 2.08

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:

_____ Initials — 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.

______________________________ ___________ ______________________________ __________

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

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, 30 N. Michigan Ave., Suite 2015, Chicago, IL. 60602

Immunization History

May be filled out by ***parent or doctor***

Provide a copy of the *school immunization record* if you cannot locate complete information

Immunization History:

Record the date (Month & Year) of basic immunizations & most recent Booster doses.

VACCINES	Month & Year of Basic Immunization	Mo. & Yr. of Last Booster
Diphtheria Pertussis (Whooping Cough) Tetanus or **DTaP**		
Tetanus Diphtheria or **TD**		
Tetanus		
Injectable/Inactivated Polio- (Salk) - **IPV**		
Oral Polio (Sabin) - **OPV**		
Measles (Hard Measles, Red Measles, Rubella) - **MMR**		
Mumps		
Rubella (German Measles, 3 – Day Measles)		
Tuberculin Test Given (Most recent) - **TB**		
Haemophilus Influenza b **(HIB)**		
Hepatitis B: *****Please List all 3 shots in series*****	1. 2.	3.
HVZ Chicken Pox - **Varicella**		
Meningitis- High School Recommended		

ADA Diabetes Camp Application –2009

TO BE FILLED OUT BY PARENT

Insulin Regimen

For Syringe or Pen Users ONLY: **Insulin /Carbohydrate Regimen**

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

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

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

For Pump Users ONLY: **Insulin / Carbohydrate Bolus Rates**

Instructions: Please list the type and amount of insulin given to cover each meal. *Example: 1 unit Humalog per 10 grams of carbohydrate*	
Total Calories per day	
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	

Campers Name: ___________________________________ **Date:** __________________________

ADA Diabetes Camp Application –2009

Insulin at Mealtimes:

Morning Snack

Type of insulin___________________________________

_______Unit per ______grams of carb or ______carb servings.

Do you give a correction at AM snack? _____Yes or _____No

Correction factor: _____unit for every _____points above _____ or below _____.

Lunch

Type of insulin given______________________________________
Below is the scale or amount I normally give my child. **Please provide the scale or insulin ratios.**
Example:
80-150 0 units Humalog
150-200 1.0 units
200-250 2.0 units

Insulin ratios:
Carb bolus: ______units per ______gms carb

Correction: ______units for_______points

above_____or below______.

____
____
____

Afternoon Snack ***(Due to Camp Confidence's swim time, no afternoon snack is provided- Parents will bring snack for campers at pick up as needed)***

Type of insulin___________________________________

_______Unit per ______grams of carb or ______carb servings.

Do you give a correction at PM snack? _____Yes or _____No

Correction factor: _____unit for every _____points above _____ or below _____.

PARENT'S SIGNATURE:_____________________________

DATE:____

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.

This information sheet does not need to be returned to the American Diabetes Association.

Camp Committee unable to place camper in a session:

Refund of Camp Fee & deposit

Camper Cancels after being accepted:

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

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

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

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

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

Opening Day:

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

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

ADA Diabetes Camp Application –2009

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

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

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

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

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

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

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

Late arrival or camper absence during camp session:

No Refund of Camp Fee or non-refundable deposit

ADA Diabetes Camp Application –2009

AMERICAN DIABETES ASSOCIATION

APPLICATION FOR CAMP FINANCIAL ASSISTANCE

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

NAME OF CAMPER: ____

ADDRESS: ____

CITY: ______________________________ STATE: ____ZIPCODE_____________

DATE DIAGNOSED ______________ DATE OF BIRTH ______________

NUMBER OF YEARS CHILD HAS ATTENDED CAMP: _____________

FATHER'S NAME: ____

ADDRESS (if different) ____

CITY: ______________________ STATE: __________ZIPCODE_______________

PLACE OF EMPLOYMENT: ____

HOME TELEPHONE: ______________ WORK TELEPHONE: ________________

MOTHER'S NAME: ____

ADDRESS (if different) ____

CITY: ______________________ STATE: _____________ ZIPCODE__________

PLACE OF EMPLOYMENT: ____

HOME TELEPHONE: _______________ WORK TELEPHONE: _________________

TOTAL ANNUAL INCOME: FATHER: ________________ MOTHER: ___________
Please attach a copy of your *1040, 1040-A or EZ tax form.*

Are you on Public Aid? YES NO
If yes, a copy of your medical card is required.

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

ADA Diabetes Camp Application –2009

Form H2

OTHER DEPENDENTS IN HOUSEHOLD	RELATIONSHIP TO CAMPER	AGE	STATUS – please circle		
____________________	______________	_______	Employed	Student	Other
____________________	______________	_______	Employed	Student	Other
____________________	______________	_______	Employed	Student	Other
____________________	______________	_______	Employed	Student	Other
____________________	______________	________	Employed	Student	Other

NAME OF CAMP APPLIED TO:____

ADDRESS OF CAMP: ____

CITY: _______________________ STATE: ___________ZIPCODE_______________

DATE/SESSION OF CAMP: ____

PLEASE NOTE: You must complete a separate registration form to attend camp in addition to this application for financial assistance.

PREVIOUS CAMP ATTENDANCE AND SPONSORSHIP:

CAMP:__________________ DATE:___________ Financial Aid Given YES NO

CAMP:__________________ DATE:___________ Financial Aid Given YES NO

CAMP:__________________ DATE:___________ Financial Aid Given YES NO

CAMP:_________________ DATE:___________ Financial Aid Given YES NO

HAVE YOU MAILED A CAMP REGISTRATION FORM FOR THE ABOVE CAMP?
YES NO
*__Note: You must be registered to apply for financial assistance__.

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

I (MY CHILD) WOULD LIKE TO ATTEND CAMP BECAUSE: (Use reverse if needed)

ARE YOU/YOUR CHILD A MEMBER OF THE AMERICAN DIABETES ASSOCIATION?
_______YES____ NO
If NO, would you like to receive membership information?_______

You will be notified by the American Diabetes Association if you qualify for total or partial financial assistance. Please submit your camp application to the camp with a notation that you have applied to the American Diabetes Association (ADA) for aid. We will advise you and the camp of the financial aid decision.