

Camp Independence

Dear Parents and Prospective Camper:

Thank you for your recent request for information about **Camp Independence** which is being held August 3-6, 2009 at Camp Buckhorn within Paris Mountain State Park.

Our camp provides camping for young people between the ages of 6-12 who have diabetes, as well as, their siblings and friends. Camp Independence provides a safe, medically supervised camping experience for children with diabetes. It is hoped that each child who attends camp grows as an individual through the ideas and experiences shared.

Camp is a place to have FUN and meet other children who also have diabetes. Camper activities include field games, arts and crafts, tile painting, natured walks, water games, and much more!

While having diabetes is not dwelled upon at camp, opportunities to learn are offered in informal settings. In years past, campers have described their experience at camp as educational and fun!

This year we can accommodate 50 campers. Applications are reviewed and filed according to priority and date of arrival at the American Diabetes Association office. Please be sure to meet deadlines and return all requested forms. All forms are due by July 24, 2009. It is imperative that all forms are accurately and completely filled out and received by the due date in to adequately prepare for each camper. Campers who have not returned complete payment and all completed forms by July 24, 2009 will be removed from the list of attendees and replaced with campers on the waiting list.

Once all the 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. If you are interested in attending Camp Independence, please complete the enclosed forms.

Please return the following forms accordingly:

Campers **WITH** diabetes:

Health Evaluation and Information Form
Physical Form
Self-Care Questionnaire
Dietary Questionnaire
HIPAA Release Form
Consent Form

Campers **WITHOUT** diabetes:

Medical Information/Registration Form
Consent Form
HIPAA Release Form

Return all forms to Camp Independence, 222 S. Church Street, Suite 336M, Charlotte, NC 28202. You may also reach me at 888.342.2383 ext. 3262 or enwilson@diabetes.org.

Sincerely,

Emily Wilson
Programs Manager
American Diabetes Association- Central Carolinas



Camp Independence

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 July 24, 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 8/2/99);

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

Table with 6 columns: Ear Infections, Rheumatic Fever, Convulsions, Chicken Pox, Hay Fever, Insect Sting Allergy, Ivy Poisoning, etc., Asthma, Drug Allergies: Penicillin, Other Drugs, Diphtheria/Pertussis/Tetanus (DPT), Tetanus/Diphtheria (TD), Polio (Salk or Sabin), MMR 1 (Measles, Mumps, Rubella), MMR 2, Hepatitis B

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.

PHYSICAL FORM- TO BE COMPLETED BY LICENSED PHYSICIAN

HEALTH EVALUATION FOR (NAME) _____ Date of Examination _____

This examination should be performed within the 12 months prior to August 2, 2009. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Ht _____ Wt _____ BP _____ HbA₁C (Date) _____ Result _____

/ Satisfactory X Not Satisfactory 0 Not Examined

CODE: _____

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 _____

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

***MANDATORY FOR ALL CHILDREN WHO DO NOT HAVE DIABETES ATTENDING CAMP
INDEPENDENCE***

MEDICAL INFORMATION/REGISTRATION FORM

Name _____

Has your child traveled outside the United States in the past year? _____ If yes, list countries: _____

Is there anything that you feel your child's counselor should know about your child in order to make the week at camp more enjoyable for your child and the camper group? _____

Are you aware of any current health problems? _____

Now under medical care or taking medication? If yes, please list conditions and medications: _____

Allergies (foods, medications, insects, plants, animals) _____

This section must be completed and signed by physician

Date: _____ Height: _____ Weight: _____
Vision: Normal _____ Glasses _____ Contacts _____
Hearing: Normal _____ Abnormal _____

Check if normal, circle if abnormal and give details below:

Growth, development _____ Teeth, tonsils _____ Genitourinary _____
Skin, glands, hair _____ Respiratory _____ Skeletomuscle _____
Head, neck, thyroid _____ Cardiovascular _____
Eyes, ears, nose _____ Abdomen _____

Please give details for any items circled above as abnormal.

Do you recommend any limitations on child's activity while at camp?

No ___ Yes ___

If yes, please describe: _____

Physician's Signature

Date

Mail completed form to:
American Diabetes Assoc.
ATTN: Emily Nivens
222 S. Church St., Suite 336M
Charlotte, NC 28202
Or Fax to: 704-373-9113

(*PLEASE ATTACH CURRENT IMMUNIZATION CERTIFICATE***)**

Camp Independence Self Care Questionnaire- 2009

First Name _____ Last _____ DOB _____ Age _____

Date Diabetes Diagnosed _____ Type (circle one): 1 2

ORAL MEDICATIONS Name: _____	Dose: _____	Time(s) _____
Name: _____	Dose: _____	Time(s) _____
Name: _____	Dose: _____	Time(s) _____
Name: _____	Dose: _____	Time(s) _____

Please indicate the brands and types of insulin and diabetes supplies you use.

Please Circle All That Apply:

INSULIN - Please look on insulin bottle for the following information:

Brand: Novo Lilly Aventis

Type: NPH Lantus Lente Regular Humalog Novolog 70/30 75/25 Apidra Levimir

Packaging: Cartridge Pre-filled pen Vial

PUMP – Animas Cozmo Minimed Omnipod Other Pump _____

Type of Infusion Set _____ ******Please bring your own pump supplies!!!**

GLUCOSE METER - One touch -Ultra Accucheck Advantage-Compact-Aviva Ascencia - Breeze-Elite-Contour BD Logic-Link Freestyle-Flash Cozmonitor Other Meter _____

INJECTIONS TIME / UNITS / INSULIN TYPE

_____ time / _____ units / _____ insulin type from _____
 _____ time / _____ units / _____ insulin type from _____
 _____ time / _____ units / _____ insulin type from _____
 _____ time / _____ units / _____ insulin type from _____
 _____ time / _____ units / _____ insulin type from _____
 _____ time / _____ units / _____ insulin type from _____

INSULIN PUMP BASAL RATE

_____ to _____ units
 _____ to _____ units
 _____ to _____ units
 _____ to _____ units
 _____ to _____ units
 _____ to _____ units

Sliding Scale

_____ units if _____ units if _____
 _____ units if _____ units if _____
 _____ units if _____ units if _____
 _____ units if _____ units if _____

Bolus dose(s) _____ units per _____ grams carb

Sliding scale _____ units if _____ units if _____
 _____ units if _____ units if _____
 _____ units if _____ units if _____

Do you (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 _____/day 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? _____

Last Hemoglobin A1C value: _____ **date:** _____

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

Reviewed by Parent / Guardian (signature) _____

Dietary Questionnaire 2009

Office use only

Camper's name _____ Nickname _____

Cabin _____

Primary Parent/Guardian Home Phone _____ Email _____

Table _____

Does camper have food intolerance or allergies? (Please list) _____

RD _____

Does camper require a gluten-free diet? (circle one) Yes No

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. Please indicate the **usual range** of carbs on **Pattern A** below

_____ 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

Prospective Camper
CAMP INDEPENDENCE CONSENT FORM

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

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.

_____ **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

Insurance Company _____ Policy Number _____

Group Number _____ Name of Policy Holder _____

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