



**Camp John Warvel
American Diabetes Association
Counselor/Therapist/Physician Questionnaire**



To be completed by camper's health care provider

Please complete sign, date and return to: American Diabetes Association, Indiana Area
6415 Castleway W. Dr., Suite 114
Indianapolis, IN 46250
(317) 352-9226, ext. 6727
FAX: (317) 594-0748

Deadline: May 22, 2009. 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:



**Camp John Warvel
American Diabetes Association
2009 Camper/Caregiver Behavior Contract**



Concerning Rules & Expectations at Camp

I will stay on the property during the camping session.

I will not intentionally injure or endanger myself or any other person either physically or emotionally. This includes keeping my blood sugar extremely high or low on purpose.

I will respect the environment, Camp, property of Camp and personal property of others. If I do not, my family will be responsible for damages caused.

I will not use bad / inappropriate language.

I will not engage in any sexual contact or use language of a sexual nature

I will not use tobacco products, drugs, alcohol, or weapons.

I will demonstrate respect for staff and fellow campers at all times.

I will not engage in teasing, harassment or ethnic /racial /religious/political slander of any person or group.

If I am with someone who is breaking one of the above rules, I can also be dismissed.

If I do not follow these rules, I

- 1) Can be promptly dismissed from Camp.
- 2) Must have parent/guardian come to Camp to pick me up.
- 3) Forfeit all Camp fees.
- 4) Risk losing the privilege of returning to Camp in the future.

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

I will treat all campers and staff during and after Camp with respect. This means that I will not participate in any phone, online, email, instant messaging or text messaging of a threatening, bullying or inappropriate nature. If I do, I may not be allowed to attend Camp.

Camper Signature

Parent/Guardian Signature

Date

Date



**Camp John Warvel
American Diabetes Association
2009 Medical Form/Health Evaluation**



**To be completed by camper's diabetes health care provider
DUE NO LATER THAN MAY 22, 2009**

PHYSICIAN'S STATEMENT

Child's Name _____ Gender _____ Date of birth _____

DIABETES

Child has: Good _____ Fair _____ Poor _____ control of diabetes.

With what management issues could the child use assistance/additional education/training while at camp?

What was child's last Glycosylated Hemoglobin (A1C)? _____ Normal range _____ Date done _____

Does the child have more problems with hyper- or hypoglycemia? _____

Severity and frequency of reactions: _____

INSULIN Please circle the source and type of insulin taken:

Source: Lilly Novo-Nordisk Aventis

Type: Humalog Novolog Apidra Regular NPH Lantus Levemir 75/25 70/30
Other _____

Present insulin doses:
Breakfast Lunch Dinner Bedtime

Long-Acting

Short-Acting

Boluses (if used) _____ u/ _____ g Carb _____ u/ _____ g Carb _____ u/ _____ g Carb _____ u/ _____ g Carb

Correction (if used)
BS - _____ / _____ BS - _____ / _____ BS - _____ / _____ BS - _____ / _____

Correction Factor (if used):

Snack doses:

Time of snack: _____ am/pm	Food dose (if used): _____ u/ _____ g Carb	Correction(if used) BS - _____ / _____
Time of snack: _____ am/pm	Food dose (if used): _____ u/ _____ g Carb	Correction(if used) BS - _____ / _____
Time of snack: _____ am/pm	Food dose (if used): _____ u/ _____ g Carb	Correction(if used) BS - _____ / _____

Insulin Pump:

Basal Rates: 12 am- _____ u/hr _____ - _____ u/hr _____ - _____ u/hr _____ - _____ u/hr
_____ - _____ u/hr _____ - _____ u/hr _____ - _____ u/hr _____ - _____ u/hr

OR ATTACH A COPY OF YOUR PATIENT'S CURRENT INSULIN DOSAGE

(over)



**Camp John Warvel
American Diabetes Association
2009 Medical Form/Health Evaluation**



NUTRITION PLAN

We will begin using the meal pattern the child is currently using at home. It has been our experience that this meal plan may need to be adjusted due to altered activity levels while at camp. A child on a free diet will be given a meal plan appropriate to weight and age, but may have it changed to meet the desires of the child and the need for adequate control. **Circle type of diet followed:** **Exchange** **Carb Counting** **Other**_____

HEALTH EVALUATION (To be done within 90 days prior to the start of camp)

HEENT: _____

CHEST: _____

HEART: _____

ABDOMEN: _____

EXTREMITIES: _____

CONDITION OF INJECTION SITES: _____

NEUROLOGICAL: _____

Does the child have any other chronic disease or disability? _____

Do you have any specific suggestions as to the care of this particular child? _____

Other Medications chronic and prn that the child takes (Name, Dosage, Frequency)

Does this child have any known drug allergies? _____

Do you approve of this child attending camp? Yes No

During the child's stay at camp he or she will be monitored closely. No alterations in management will be made without the approval of the Medical Director. Every effort will be made to maintain your basic management program. If you desire that no alteration be made in management of the diet or insulin program, please state below. All campers will be instructed to return to their home diet plan and insulin dosage at the completion of camp. If major changes in insulin requirements are made during camp, you will be contacted by the Medical Director regarding possible changes to the insulin dosage.

Physician's Signature: _____ Date _____

NAME PRINTED: _____

ADDRESS: _____

OFFICE PHONE: _____ EMERGENCY PHONE: _____

PHYSICIAN'S REPORT SHOULD BE RETURNED NO LATER THAN MAY 23, 2009: American Diabetes Association, 6415 Castleway West Drive, Suite 114, Indianapolis, IN 46250, **or faxed to: 317-594-0748**



**Camp John Warvel
American Diabetes Association
Authorization to Disclose Personal 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

(Over for Spanish version)



Camp John Warvel
American Diabetes Association
Authorization to Disclose Personal Information



AUTORIZACIÓN PARA COMPARTIR INFORMACIÓN DE SALUD PERSONAL
HIPAA (Health Insurance Portability and Accountability Act)

Nombre del Participante: _____

Fecha de Nacimiento del Participante _____

Nombre del Padre con la Custodia /Guardián Legal _____

- Autorizo a American Diabetes Association (ADA) a compartir información de salud de la persona anteriormente mencionada según se indica a continuación:

El propósito de compartir la información es para promover o hacer publicidad al programa de campamento de American Diabetes Association, y/o recolectar fondos para American Diabetes Association:

Marque todas con las que está de acuerdo:

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

Foto del participante u otro documento de identificación

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

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



Camp John Warvel American Diabetes Association 2009 Nutrition Information



NUTRITION INFORMATION

Please answer the following questions and return to the ADA office before May 22, 2009. Please provide an approximate number of carbs eaten at meals and snacks if your child is on carb ratios or an insulin pump. This will help with food preparation to provide the appropriate amount of food at meals and snacks.

Name of Camper _____

1. Circle current diet used:

Exchange Carb Counting Carb Ratios Other _____ Follows no specific meal plan

When do you have snacks at home? Morning _____ Afternoon _____ Bedtime _____

Do you want your child to receive additional snacks or a reduction in insulin for increased activity?

_____ Additional snacks _____ Insulin Reduction

Do you measure and weigh foods at home? _____ Yes _____ No

If your child is aged 13-15 please provide a range of carb grams

2. Please fill in the number of servings for each group at each meal and snack.

Breakfast	Lunch	Dinner
_____ Carbohydrate servings or grams	_____ Carbohydrate servings or grams	_____ Carbohydrate servings or grams
_____ Starch	_____ Starch	_____ Starch
_____ Fruit	_____ Fruit	_____ Fruit
_____ Milk	_____ Milk	_____ Milk
_____ Meat group	_____ Meat group	_____ Meat group
_____ Fat group	_____ Fat group	_____ Fat group

Morning Snack	Afternoon Snack	Bedtime Snack
_____ Carbohydrate servings or grams	_____ Carbohydrate servings or grams	_____ Carbohydrate servings or grams

3. How much does your child understand about his/her nutrition plan? (check appropriate statements)

- _____ Knows to eat only amount allowed at meals and for snacks.
- _____ Knows what to take for when his/her blood sugar is too low.
- _____ Knows how to vary eating related to exercise.
- _____ Knows examples of foods from each exchange list.
- _____ Knows how to use exchange lists.
- _____ Knows not to skip meals.

4. How much responsibility does your child have for his/her diet? (check appropriate statements)

- _____ Parent does everything
- _____ Child helps select food choice
- _____ Child helps prepare meals
- _____ Child selects food choice
- _____ Child prepares own meals
- _____ Child helps measure or weigh food
- _____ Child helps measure or weigh food



**Camp John Warvel
American Diabetes Association
2009 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.

Refund of Camp Fee and deposit

- Camp Committee unable to place camper in session

Refund of Camp Fee less non-refundable deposit

- Written cancellation received 60 days prior to Camp opening day
- Serious illness or death in the family after accepted but before Camp begins
- Camper not accepted due to condition found by Camp medical staff during opening day health screening
- Camp closed prior to session due to fire, epidemic, or natural disaster

Refund of 50% of Camp Fee less non-refundable deposit

- Written cancellation receive 59-30 days prior to Camp opening day
- Early closure during first half of Camp due to fire, epidemic, or natural disaster

Refund of 25% of Camp Fee less non-refundable deposit

- Written cancellation received 29-15 days prior to Camp opening day

No refund of Camp Fee or non-refundable deposit

- Written cancellation received 14 days or less prior to camp opening day
- Camper not showing up on opening day.
- Illness during Camp; Camp physician recommends camper can remain in camp, but parent elects to withdraw camper
- Camper elects to leave Camp early (camper homesick; camper wanting to return home for various reasons)
- Camper sent home for reasons determined appropriate for protection of said camper, other campers or staff
- Early closure of Camp during last half of camper session due to fire, epidemic or natural disaster
- Late arrival or camper absence during camp session

Refund of Camp Fee prorated less non-refundable deposit

- Illness during Camp; Camp physician recommends camper returns home
- Serious illness or death in family during Camp; camper removed at parent's request



**Camp John Warvel
American Diabetes Association
2009 Camper Priorities**



Camper applications will be processed in the order in which they are received and based on the following criteria. **Deadline for submitting applications is MAY 7, 2009.**

Priority 1: New camper, a child or adolescent with diabetes who has never attended Camp John Warvel and has had diabetes less than one year.

Priority 2: New camper, a child or adolescent with diabetes who has never attended Camp John Warvel and has had diabetes more than one year.

Priority 3: New camper, a child or adolescent who has attended a diabetes camp (residential or day) other than Camp John Warvel.

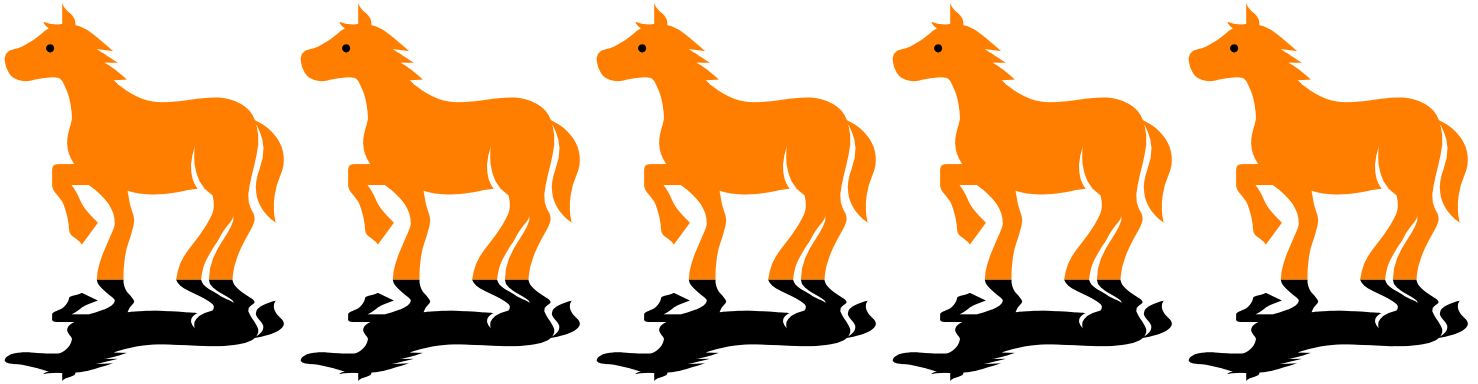
Priority 4: Former camper, a 15-year-old who will have a last opportunity to attend camp.

Priority 5: Former camper, a child or adolescent who has been to a diabetes camp one or more times. The following will be considered: (a) length of time since last camp experience; (b) evaluation from previous camp experience; (c) age.

Children in Priorities 1 and 2 are accepted first.



Camp John Warvel
American Diabetes Association
2009 Horse Riding Form



Attention Camp John Warvel Campers!

This year you will have the opportunity to ride Camp Crosley's horses in the riding arena. If you chose to participate in this activity, you must have a pair of hard-soled shoes, e.g., old dress shoes, hiking boots, any leather shoes with a hard sole (Please do not buy special shoes. This activity will be offered only one time during the session, and we would not advise spending extra money on this). Gym shoes or flip-flops will not be allowed for this activity! **Parents please fill out and return the bottom of this form. Your child must be signed up prior to camp** so that we may work this into individual camper's schedules. If you do not wish to ride, another activity will be provided during this time.

Due to an increase in camp costs, families wanting their child to ride horses will be asked to pay an additional \$20 fee.

Please return to the American Diabetes Association by May 22, 2009.

- Yes my child, _____, is interested in taking part in the horse riding activity. Enclosed is the additional \$20 fee.
- Yes my child, _____, is interested in taking part in the horse riding activity. I am applying for financial assistance.



Camp John Warvel American Diabetes Association 2009 Insulin Form



RETURN TO AMERICAN DIABETES ASSOCIATION NO LATER THAN MAY 22, 2009

INSULIN INFORMATION

Name of Camper _____ Child's Age: _____ Birthdate: _____ Height: _____ Weight: _____

Please circle the manufacturer of insulin taken: Lilly Novo-Nordisk Aventis

Please circle the type(s) of insulin taken:

Regular NPH Humalog 70/30¹ 75/25 Lantus Levemir
Novolog 50/50 Novolog Mix Apidra Other _____

Present insulin doses:

Breakfast Lunch Dinner Bedtime

Long-Acting

Short-Acting

Boluses (if used)

_____ u/_____ g Carb _____ u/_____ g Carb _____ u/_____ g Carb _____ u/_____ g Carb

Correction (if used)

BS - _____/_____ BS - _____/_____ BS - _____/_____ BS - _____/_____

Correction Factor (if used):

Snack doses:

Time of snack: _____ am/pm	Food dose (if used): _____ u/_____ g Carb	Correction (if used) BS - _____/_____
Time of snack: _____ am/pm	Food dose (if used): _____ u/_____ g Carb	Correction (if used) BS - _____/_____
Time of snack: _____ am/pm	Food dose (if used): _____ u/_____ g Carb	Correction (if used) BS - _____/_____

Insulin Pump:

Basal Rates: 12 am- _____ u/hr _____ - _____ u/hr _____ - _____ u/hr _____ - _____ u/hr
 _____ u/hr _____ - _____ u/hr _____ - _____ u/hr _____ - _____ u/hr

What sites does child use for injection/pump site insertions? (please circle)

Arms Stomach Hip Thigh

Any other daily medications taken:

Medicine Name	Dose	When Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is child able to recognize symptoms of low blood sugar? Yes _____ No _____

Does child give own insulin? _____ Yes _____ No Sites used _____

Does child draw up own insulin? _____ Yes _____ No _____ Sometimes

If your child shows an interest, can they be instructed in blood glucose monitoring? _____ Yes _____ No

If your child shows an interest, can they be instructed in drawing up insulin? _____ Yes _____ No

If your child shows an interest, can they be instructed in giving insulin? _____ Yes _____ No
