



ADA Diabetes Camp Application –2009



I

COUNSELOR/THERAPIST/PHYSICIAN QUESTIONNAIRE

To be completed by camper’s health care provider

Please complete sign, date and return to: American Diabetes Association
837 S. Hillside St.
Wichita, Ks 67211

Any delay in returning this form may result in your patient being placed on a waiting list.

To Parent: Please complete/sign this box before forwarding to health professional.

Patient’s Name _____

Parent/Legal Guardian _____

Address _____

As the parent/legal guardian, I freely give permission to my child’s therapist/counselor to release information pertaining to my child to the American Diabetes Association for their use at Camp or speak with the ADA representative concerning my child’s treatment.

Signature of Parent/Legal Guardian Date

1. How long have you known your patient? _____

2. Has your patient been compliant in attending appointments? Yes No

3. Does he/she pose any danger to self or others? Yes No
If yes, please explain.

4. Is there any prior history of suicidal ideation or attempt? Yes No
If yes, please explain.

5. Is your patient on any psychiatric medications? Yes No
If yes, please list the medication(s), strength and dosage:

6. Please list any specific recommendations that would be helpful in the care of your patient for the Camp medical staff.



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Camper/Parent Behavior Contract
Concerning Rules & Expectations at Camp



I will stay on the property during the camping session.

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

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

I will not use bad / inappropriate language.

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

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

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

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

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

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



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AMERICAN DIABETES ASSOCIATION AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

HIPAA (Health Insurance Portability and Accountability Act)

Camper Name: _____

Camper's Date of Birth _____

Name of Custodial Parent /Legal Guardian _____

- I hereby authorize the American Diabetes Association (ADA) to release the above named Camper's Personal Health Information (PHI) as described below:

The purpose of this disclosure is to promote the ADA Camp program, publicize the ADA Camp program, and/or fund-raise for the American Diabetes Association:

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



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Prospective Camper CONSENT FORM

- I hereby apply for admission of my child (name) _____ to the summer Camp for children with diabetes operated by the American Diabetes Association.
- I understand my child shall be subject to the same Camp rules as the other children at Camp.
- I consent to my child receiving any and all medical care, treatment and testing the Camp's health care provider in charge determines is medically necessary, in his or her sole discretion (including without limitation diet, insulin dosage and/or type 2 oral medication and daily blood glucose monitoring). I consent to my child receiving any other medically necessary medical care, treatment, and testing the Camp diabetes care provider in charge may cause to have performed by a licensed health care provider, emergency medical personnel at any facility, clinic or hospital while my child is a Camp participant, including without limitation tuberculin test and x-ray if the test is positive, and blood testing for Hepatitis B and/or HIV antibodies, in the event of an accidental finger prick where there may be possibly contaminated material (such as a syringe needle or lancet). I agree that I am personally responsible for any and all medical charges and expenses resulting from the treatment of my child either on the Camp property or at an off-site facility and that my insurance, if any, shall be the primary insurance plan.
- I further consent to the release of any and all test results to the Public Health Authorities, if such release is required by any law, statute, or regulation.
- I freely give permission to my child's health care providers (including without limitation physicians, physician's assistants, clinical nurse practitioners, R.N.s, R.D.s, certified diabetes educators, therapists, psychologists, etc.) to release any and all information pertaining to my child to the American Diabetes Association, and any third party health care providers or institutions the American Diabetes Association deem medically necessary to treat my child during the Camp session. This consent expires at the end of the camp session or the last day any necessary paperwork arising from the treatment of my child is complete, whichever date is later, and may be revoked at anytime by giving written notice to the American Diabetes Association
- I hereby grant my consent and permission for my child to leave the premises of the camp on occasional trips to nearby points of interest under the supervision of the Camp Staff.
- I understand that while the American Diabetes Association may supply insulin, syringes, monitoring supplies and routine first aid care required at Camp, I shall be primarily responsible for the cost of all other medical treatment of my child, including but not limited to laboratory tests, x-rays, and emergency treatment at a hospital or clinic.
- I understand that ADA is not responsible for any damage, maintenance, repair or replacement of any durable medical equipment (including insulin pumps, continuous glucose monitors, hearing aids) my child may use during camp, and other risks assumed in the use of such devices
- I hereby waive, release and shall indemnify ADA against any and all claims, injury, damages or liability which may arise from my child's use of any durable medical equipment including without limitation misuse, malfunction or medical care in connection with such durable equipment.
- I understand that the purpose of the continuous glucose monitor is to show trends and not to adjust insulin. No alterations in my child's medical plan will be made based on CGM readings/warnings (alarms) without discussion with and approval of camp medical staff directly responsible for my child's care.
- In order to assist in the prompt treatment of my child, I hereby consent to any necessary medical or surgical treatment and testing of my child of an emergency nature and my child receiving off-site medical care at the closest available medical facility. Below my signature, I have listed the policy number for any applicable policies of hospitalization insurance that I carry on this child (including Medical Assistance). I authorize the appropriate representative of the American Diabetes Association to release the information concerning my hospitalization insurance to any provider of medical or surgical services to my child.
- In consideration of the American Diabetes Association allowing my child to attend its summer Camp, I hereby knowingly waive and release the American Diabetes Association, its agents, employees, assigns, volunteers, directors, officers and medical staff, from any and all liability or claim arising out of and in connection with my child's participation in camp for any reason.
- I have read and am aware of and shall abide by the Camper Pick-Up policies.

Please check and initial one of the two following statements:

_____ I do consent to the placement of my child's name, address, phone number and email address in a Camper Directory that is
Initials given to each camper.

_____ I do not consent to the placement of my child's name, address, phone number and email address in a Camper Directory
Initials that is given to each camper.

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

Signature of Father/ Mother

Date

Signature of Legal Guardian

Date

The following information is for hospital / immediate care center billing purposes only:

Insurance Company _____ Policy Number _____ Group Number _____

Policy Holder Information: Name _____ Birth Date _____
SSN _____

Child's Information: Name _____ Birth Date _____
SSN _____



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CAMP REFUND POLICY

The American Diabetes Association strives to control the costs associated with providing camp in order to keep the fee families pay as reasonable as possible. ADA underwrites the cost of every camper by at least 50% of the fee that is charged to families.

In order to provide the camp program, ADA must contract and pay for the procurement of staff, a camp facility and all supplies up to 10 months prior to camp. We must pay all expenses for a guaranteed number of campers regardless of the number that actually attend. Therefore, this policy is to ensure that we can continue to make camp affordable for families, continue providing financial assistance to families who need it, and have time to fill vacancies from the camp waiting list.

Camp Committee unable to place camper in a session:

Refund of Camp Fee & deposit

Camper Cancels after being accepted:

- a. Written cancellation received 60 days prior to camp opening day.
Refund of Camp Fee less non-refundable deposit
- b. Written cancellation received 59 to 30 days prior to camp opening day.
Refund of 50% of Camp Fee less non-refundable deposit
- c. Written cancellation received 29 to 15 days prior to camp opening day:
Refund of 25% of Camp Fee less non-refundable deposit
- d. Written cancellation received 14 days or less prior to camp opening day:
No refund of Camp Fee or non-refundable deposit.
- e. Serious Illness or death in family:
Refund of Camp Fee less non-refundable deposit

Opening Day:

- a. Camper not accepted due to condition found by camp physician during camp opening day health screening.
Refund of Camp Fee less non-refundable deposit
- b. Camper not showing on opening day.
No Refund of Camp Fee or non-refundable deposit



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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



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APPLICATION FOR CAMP FINANCIAL ASSISTANCE

This application must be completed in its entirety. **PLEASE PRINT!**

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: _____



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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

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

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)

You will be notified by the American Diabetes Association if you qualify for total or partial financial assistance.

RETURN THE APPLICATION FOR SCHOLARSHIP WITH COPY OF MOST RECENT FEDERAL TAX RETURN (Form 1040) TO: 837 S Hillside, Wichita, KS 67211

I hereby certify that the foregoing information is true and correct. ALL INFORMATION IS STRICTLY CONFIDENTIAL.

PARENT'S SIGNATURE: _____ DATE: _____

Aid awarded:	Camp notified: ___/___/___
	Family notified: ___/___/___



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CAMP DISCOVERY MEDICAL QUESTIONNAIRE (Must be completed by Parent and/or Guardian)

Please Print in Black Ink

Camper's Name: _____

Insulin Brand(s)		
Usual Time	Dose	Type: Lantus, Humalog, Novolog, 70/30, 25/25, Levemir, NPH, etc.
Breakfast		
Lunch		
Supper		
Bedtime		
Pump Brand / Model #:		Insulin Dilution:
Basal Rates:		
Has your child ever used an insulin pen? What brand (s)?		
Usual Exercise <i>Please circle usual level of activity</i>		
Lots of computer, TV, or books		Some outdoor activity
Soccer or other sports with friends round		Competitive sports year round
Other types of activity:		
Medication <i>Please Print</i>		
Name of Medication	Dosage	Frequency

Meal Plan		
# of Calories:	# of Meals	# of Snacks
Please circle system used at home:		
Food: Weighed Measured Estimated		
Points/Carb distribution		Insulin to carb or pt ratio
Breakfast: _____		_____
AM Snack: _____		_____
Lunch: _____		_____
PM Snack: _____		_____
Supper: _____		_____
Bedtime Snack: _____		_____
Home Monitoring <i>Bring 1 week of records to camp</i>		
Brand of Meter:	# of Tests per day:	Days per week:
Brand of Ketone testing strips: _____		
Recent Ketones: Yes or No		
Hypoglycemia		
Low Blood Sugars		
Usual # per month: _____		
Usual times of day: _____		
Ever had unconsciousness or seizure from a low blood glucose: Yes or No		
When: _____		
Does your child have warning symptoms: Yes or No		
Circle usual symptoms: hungry, sweaty, hostile, irritable, drowsy, confused, headache, weepy, or other _____		

Does your child inform others when low? Yes or No		
Usual response time: _____ minutes		
Usually treat with: _____		



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CAMPER NAME: _____

IMMUNIZATIONS – Please attach documentation or certificate. The child will not be allowed to check in without certificate.

MEDICATION OR FOOD ALLERGIES:

Other information that may be helpful:

How often does camper go to the bathroom at night? _____ Bedwetting: _____ Yes _____ No

PHYSICAL EXAM/MEDICAL HISTORY (PHYSICIAN TO COMPLETE THIS SECTION)

Please review the parent completed information for accuracy. Your signature indicates review of the entire form.

Date of diabetes diagnosis: _____ Date of exam: _____

BP _____ Height _____ Weight _____ A1C _____ Date: _____

Physical exam within normal limits: Yes ___ No ___ If no, please describe abnormal

Other medical or behavioral diagnosis: please describe below

Recommendation regarding activity: (please circle) FULL ACTIVITY RESTRICTED ACTIVITY

Please state restrictions:

Particular problems with diabetes management i.e. diet, injections, emotional adjustment etc.

Are there any reasons that you feel your patient should not participate in the American Diabetes Association summer camp program? Yes ___ No ___ If yes, why not?

I AGREE WITH OR HAVE PROVIDED COMMENTS ABOUT THE MEDICAL INFORMATION PROVIDED BY THE PARENT. CAMP MEDICAL STAFF HAS MY PERMISSION TO ADJUST INDIVIDUALS MEAL PLAN AND INSULIN TO BALANCE WITH INCREASED EXERCISE.

SIGNATURE OF PHYSICIAN/PA/NURSE PRACTITIONER

DATE

Printed Name: _____

Address: _____ Phone: _____

**MUST BE SIGNED AND RETURNED TO ADA PRIOR TO CAMP SESSION
CHILD WILL BE TURNED AWAY WITHOUT COMPLETED FORM ON FILE
INCLUDING A COPY OF THE IMMUNIZATIONS PRIOR TO CAMP SESSION**