



**Retreater/Parent Behavior Contract
Concerning Rules & Expectations at Youth Retreat**

I will stay on the property during the Youth Retreat 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, Youth Retreat, 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 retreaters 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 Youth Retreat.
- 2) Must have parent/guardian come to Youth Retreat to pick me up.
- 3) Forfeit all Youth Retreat fees.
- 4) Risk losing the privilege of returning to Youth Retreat in the future.

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

I will treat all retreaters and staff during and after Youth Retreat 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 Youth Retreat.

Retreater Signature

Parent/Guardian Signature

Date

Date

Mail Form To: American Diabetes Association, 3203 3rd Avenue North, Ste. 203, Billings, MT 59101



ADA Montana Youth Retreat, July 30-August 2, 2009



Montana Youth Retreat Application – 2009



Retreater Medical Form / Health Evaluation

To be completed by retreater's diabetes health care provider

Dear Doctor:

Your cooperation in supplying the following information about an applicant for Montana Youth Retreat will be greatly appreciated. **The child will not be accepted at Retreat without this form.**

To Parent: Please complete boxed information BEFORE submitting to Physician

Name of applicant: _____ Gender: (circle one) M F

Date of Birth: __/__/__

Date of Exam: _____

Last hemoglobin A1C: _____ (lab normal range _____) Date: _____

Target Blood glucose range: Pre-breakfast _____ Pre-lunch _____
Pre-supper _____ Bedtime _____

What is child's nutrition program? _____

Current Weight _____ Current Height: _____

Is child on a continuous glucose monitoring system? Yes No

If yes, what system? _____

Is camper in a clinical trial that will require specific medical treatment/care at Camp?

Yes No If yes, please **attach** specific information.

Please Note: It may be necessary, with more exercise to increase caloric intake. This will be done under the Camp physician's supervision and noted in the camper's chart.

INDICATE THE LAST PRESCRIBED INSULIN DOSE FOR THE CHILD

If child is on a pump, please list insulin to carb ratio for each meal/snack

UNITS/TYPE (per grams of carbohydrate if applicable)

Before Breakfast _____ Before Lunch _____
Before Supper _____ Before Bedtime _____
Morning Snack _____ Afternoon Snack _____
Bedtime Snack _____

PLEASE CIRCLE ALL THAT APPLY:

Lilly (Humulin) Humalog, Humulin N, Humulin R, Humulin 70/30, Humulin 50/50,
Humalog Mix 75/25, Humalog Mix 50/50
Novo-Nordisk (Novolin) Novolog, Novolin N, Novolin R, Novolin 70/30, Novolog Mix 70/30, Levemir,
ReliOn
Sanofi-Aventis Lantus, Apidra

Other Insulin (Specify) _____

Pen _____

Pump: Please list brand and model: _____

What is the correction dose of insulin prescribed for high glucose boluses? (e.g. 1 unit per 50 mg/dl for BG>140) _____

Note: If insulin dose is changed during Camp, parent will be notified at departure interview.

Have any complications of diabetes or disabilities been detected? Yes No

If yes, please specify: _____

Emotional Status: It is imperative that the Camp medical team be aware of any family or camper emotional problems which may affect the camper's health at Camp or the health and safety of other campers and staff.

Has the child or family been in counseling over the past year? Yes No

Has the family been referred for counseling? Yes No

If yes, what is the nature of the problem?

Do you have any specific concerns regarding the management of this child's diabetes or health at Camp? Yes No If yes, please explain:

Do you have any suggestions for the care of this particular child at Camp or for areas of diabetes management and education focus? Yes No If yes please explain:

Do you recommend any limitations on child's activity while at Camp? Yes No

If yes, please describe: _____

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?

Physician's name (typed or printed) _____

Address: _____ Phone: (____) _____

Physician's Signature: _____

Mail Form To: American Diabetes Association
3203 3rd Avenue North, Ste. 203
Billings, MT 59101
406-256-0616 phone
406-896-0289 fax



COUNSELOR/THERAPIST/PSYCHIATRIST FORM
To be completed by retreaters' health care provider

Please complete sign, date and return to: American Diabetes Association
Attention: Camp Medical Director
3203 3rd Avenue North, Ste. 203
Billings, MT 59101

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 Youth Retreat 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 Youth Retreat medical staff.

7. Are there any reasons that you feel your patient should not participate in the American Diabetes Association summer Youth Retreat program? Yes No

If yes, please explain.

8. Would you be willing to be contacted, if necessary, by telephone during Youth Retreat should a problem arise? Yes No (This will only be done if absolutely necessary.)

If yes, please include your answering service or home telephone number with area code below.

Phone Number: (_____)_____

During your patient's stay at Youth Retreat, he/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 medical, family practice, and pediatric residents, nurses and dietitians, under the direct medical supervision of an attending physician.

.....

Please print name

Signature

Date

Address:_____

City

State

Zip

Thank you for your cooperation. If you have any questions or comments, please feel free to call Trina Adams at 406-256-0616 or 1/800-766-8596.

Prospective Retreater CONSENT FORM

- I hereby apply for admission of my child (name) _____ to the summer Youth Retreat for children with diabetes operated by the American Diabetes Association.
- I understand my child shall be subject to the same Youth Retreat rules as the other children at Youth Retreat.
- I consent to my child receiving any and all medical care, treatment and testing the Youth Retreat'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 Youth Retreat 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 Youth Retreat 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 Youth Retreat session. This consent expires at the end of the Youth Retreat 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 Youth Retreat Staff.
- I understand that while the American Diabetes Association may supply insulin, syringes, monitoring supplies and routine first aid care required at Youth Retreat, 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 Youth Retreat, 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 Youth Retreat 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 Youth Retreat, 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 Youth Retreat for any reason.
- I have read and am aware of and shall abide by the Retreater Pick-Up policies.

Please initial the following statement:

_____ 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 _____

Mail Form To: American Diabetes Association, 3203 3rd Avenue North, Ste. 203, Billings, MT 59101\



ADA Montana Youth Retreat, July 30-August 2, 2009



Montana Youth Retreat 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: **American Diabetes Association, 3203 3rd Avenue North, Ste. 203, Billings, MT 59101**

Montana Youth Retreat, July 30-August 2, 2009



Insulin Regimen

Instructions to Parents: Because it is very common for a child's or teen's insulin regimen (how much insulin they take & how often) to change, please complete this form no sooner than July 1

Deadline to Return: Friday, July 10

Return To: American Diabetes Association, Montana Youth Retreat
3203 3rd Avenue North, Ste. 203, Billings, MT 59101

Insulin /Carbohydrate Regimen for Syringe or Pen Users ONLY

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	

Insulin / Carbohydrate Bolus Rates for Pump Users ONLY

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	



YOUTH RETREAT REFUND POLICY

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

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

Youth Retreat Committee unable to place retreat in a session:

Refund of Youth Retreat Fee & deposit

Retreater Cancels after being accepted:

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

Opening Day:

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

Early Departure of Individual Retreater from Youth Retreat:

- a. Illness during retreat; Youth Retreat physician recommends retreater returns home.
Refund of Retreater Fee prorated less non-refundable deposit
- b. Illness during retreat; Youth Retreat physician recommends retreater can remain in camp, but parent elects to withdraw retreater.
No Refund of Retreat Fee or non-refundable deposit
- c. Serious Illness or death in family, retreater removed at parent's request.
Refund of Retreat Fee prorated less non-refundable deposit
- d. Retreater elects to leave Youth Retreat early (retreater homesick; retreater wanting to return home for various reasons).
No Refund of Retreat Fee or non-refundable deposit
- e. Retreater sent home for reasons determined appropriate for protection of said retreater, other retreaters or staff.
No Refund of Retreat Fee or non-refundable deposit

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

- a. During the first half of retreater session.
One-half of retreat fee paid will be refunded less non-refundable deposit
- b. During the last half of retreater session.
No Refunds will be made
- c. Retreat closed prior to session due to above.
Refund of retreat fee less non-refundable deposit

Late arrival or retreater absence during retreat session:

No Refund of Retreat Fee or non-refundable deposit

