ADA Camp Rainbow –2009

Dear Parents and Prospective Camper:

Thank you for your recent pre-registration for ADA Camp Rainbow.

Our camp provides a fun filled day for young people between the ages of *3-10* who have diabetes. This day camp provides a safe, medically supervised 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.

It is imperative that all forms are accurately and completely filled out and received by the due date to adequately prepare for each camper.

Please return the following forms:

- Camper Application – to be completed by parent
- Camper/Parent Behavior Contract- to be Signed by camper and parent
- Medical Form/Health Evaluation – to be completed by diabetes health care provider
- Non-Insulin/Non Diabetes Medications Form- **THIS FORM MUST BE SIGNED BY PHYSICIAN**
- HIPPA Form- to be signed by parent
- Counselor/Therapist /Psychiatrist Form – to be complete by mental health care provider

For questions, please contact Brandi at 585-458-3040 X3472

Mail ALL Forms To:

American Diabetes Association
ATTN: Brandi Koch
160 Allens Creek Rd
Rochester, NY 14618

ADA Camp Rainbow –2009

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

Return to: **American Diabetes Association**
ATTN: Brandi Koch
160 Allens Creek Rd
Rochester, NY 14618

ADA Camp Rainbow –2009

Camper Medical Form / Health Evaluation

To be completed by camper's diabetes health care provider

Dear Doctor:
Your cooperation in supplying the following information about an applicant for **Camp Rainbow** will be greatly appreciated. **The child will not be accepted at Camp 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

ADA Camp Rainbow –2009

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
ATTN: Brandi Koch
160 Allens Creek Rd
Rochester, NY 14618

ADA Camp Rainbow –2009

COUNSELOR/THERAPIST/PSYCHIATRIST FORM

To be completed by health professional listed above

To Parent: If your child has been in counseling within the past year, please have the Counselor/Therapist/ Psychiatrist/ Psychologist complete and return this Questionnaire

Please complete sign, date and return to: American Diabetes Association
Attention: Camp Medical Director
160 Allens Creek Rd
Rochester, NY 14618

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:

ADA Camp Rainbow –2009

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

7. Are there any reasons that you feel your patient should not participate in the American Diabetes Association summer Camp program? ☐ Yes ☐ No
If yes, please explain.

8. Would you be willing to be contacted, if necessary, by telephone during Camp 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 Camp, 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 **Brandi at 585-458-3040- X3472**

ADA Camp Rainbow –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 <u>one</u> 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 <u>do</u> <u>not</u> <u>consent</u> 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_____________________

Return to: **American Diabetes Association Attn: Brandi 160 Allens Creek Rd, Rochester, NY 14618**

ADA Camp Rainbow –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**
ATTN: Brandi Koch
160 Allens Creek Rd
Rochester, NY 14618

ADA Camp Rainbow –2009

AUTORIZACIÓN PARA COMPARTIR INFROMACIÓN 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.

[ ] Otro: (especifique ________________________)

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 2019.

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

Envias esta forma a: **American Diabetes Association**
Attn: Brandi Koch
160 Allens Creek Rd
Rochester, NY 14618

ADA Camp Rainbow –2009

Immunization Records

Please be sure to have a copy of your child's immunization record on file prior to the beginning of camp. If you have not submitted, please fax to 585-458-3138 or mail to:

American Diabetes Association
ATTN: Brandi Koch
160 Allens Creek Rd,
Rochester, NY 14618.

Thank you!

ADA Camp Rainbow –2009

Authorization Form - Non-Insulin/Non-Diabetes Medications

*****To be completed by camper's health care provider*****

CAMPER'S NAME ___________________________ **Session 1**_______ **Session 2** _______

Please note the following:

1. ***As per the New York State Department of Health, a licensed physician must give written permission for our camp nurse to administer any over the counter medications to children while they are at camp.***
2. ***No prescription or over-the-counter medications will be given to your child without the doctor's signature below.***

Please list any prescription medications your child takes on a daily basis for a condition other than diabetes:			
Medication 1:	**Reason for Use:**	**Dose:**	**What Time:**
Prescribed By:	**Dr.'s phone #**	**Physician 1 Signature & Date**	
Medication 2:	**Reason for Use:**	**Dose:**	**What Time:**
Prescribed By:	**Dr.'s phone #**	**Physician 2 Signature & Date**	
Medication 3:	**Reason for Use:**	**Dose:**	**What Time:**
Prescribed By:	**Dr.'s phone #**	**Physician 3 Signature& Date**	

********Please See Reverse Side********

ADA Camp Rainbow –2009

THIS PAGE MUST BE SIGNED BY A PHYSICIAN

Please indicate (by writing 'yes' or 'no" in the center column) any over-the-counter medications that your child may take while at camp, if needed:		
My child may take:	**Yes/No**	**Other:**
Tylenol for Headache		
Advil		
Throat Lozenges		
Ibuprofen for Menstrual cramps		
Calamine lotion or Cortaid for Poison Ivy		
Pepto Bismol for Upset Stomach		
Immodium Ad for Diarrhea		
Visine		
Tums		
First Aid Cream/Neosporin		
Other (specify)		

I hereby authorize and give my consent to the American Diabetes Association Camp Nurse or the nurse designee to store, supervise, and administer the following non-insulin medications to my child

Parent/Guardian Name: ______________________________________

Parent/Guardian Signature: _____________________________________

Physician Name (Please print): _________________________________

Phyician Signature: ____ **DATE:**______________________

AMERICAN DIABETES ASSOCIATION
160 ALLENS CREEK RD
ROCHESTER, NY 14618

585-458-3040 (X 3472)
FAX: (585) 458-3138