



ADA Diabetes Camp Sioux Application –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



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Name of Applicant: _____

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 Sioux** will be greatly appreciated. **This form is due by May 15, 2009. The child will not be accepted at camp without this form.**

To Parent: Please complete boxed information BEFORE submitting to Physician

Gender: (circle one) M F

Date of Birth: ___/___/___

Date of Exam: _____

Last hemoglobin A1C: _____ Date: _____

Target Blood glucose range: Daytime _____
Bedtime _____

Additional diagnoses include : Celiac Disease Thyroid disease Other _____

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

BACKGROUND INSULIN TYPE (please circle): Lantus Levemir NPH Other _____

DOSE/TIME OF ADMINISTRATION: _____

RAPID/FAST ACTING INSULIN TYPE (please circle): NovoLog Humalog Apidra Regular

MEAL/SNACK DOSES (per grams of carbohydrate if applicable)

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

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.



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Other Insulin (Specify) _____

Injections are given by (please circle): Pen Syringe Both Specify _____

Pump: Please list brand and model: _____

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 or Fax form To: **American Diabetes Association
Camp Sioux
5100 Gamble Drive, Suite 394
Minneapolis, MN 55416
Fax: 952-582-9000**



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COUNSELOR / THERAPIST / PSYCHIATRIST FORM

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
5100 Gamble Drive, Suite # 394
Minneapolis, MN 55416
Fax: 952-582-9000

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:



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You or the person you have authorized to pick up your child must bring a photo id (driver’s license) to check out your child.

Camp Sioux Release Form

Camper Name: _____

THE FOLLOWING STATEMENT MUST BE COMPLETED AND SIGNED BY THE LEGAL PARENT/GUARDIAN.

CAMPER RELEASE STATEMENT

- I am able to pick up my child at the close of the camp session.
- I hereby authorize the Camp Sioux staff to release my child at the completion of the camp session to:
 Name: _____ Relation to camper: _____
 Address: _____ Phone: _____
 Street City/State Zip Area Code and Number

If I am unable to pick up my child on the last day of camp, I understand that this measure is taken to insure the protection of my child.

Date: _____

PARENT/GUARDIAN SIGNATURE: _____ Phone: _____



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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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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



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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 **May 1, 2009**.

Deadline to Return: May 29, 2009

**Return To: American Diabetes Association
Camp Sioux
5100 Gamble Drive, Ste. 394
Minneapolis, MN 55416**

CAMPER NAME _____

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	
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	

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	
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	



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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.

This information sheet does not need to be returned to the American Diabetes Association.

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