LIONS DIABETES CAMP HEALTH FORM- *to be completed by parent/guardian*

CAMPER'S NAME _____Birth Date:_____ PREFERS TO BE CALLED:_____
Address:_____ City:_____ Zip_____
PARENT/GUARDIAN NAME(s):_____ Phone ( )_____
_____ ( )_____
Email:_____
Camperôs Preferred Language:_____
Diabetes? ____Yes ____No **Any Medical Diagnoses?** ____Yes ____No **If yes, please list below in Health History**
Has Camper attended an overnight camp? ____Yes ____No T-Shirt size: Adult- S M L XL 2XL 3XL (circle one)

INSULIN DELIVERY:

___None ___Yes Insulin is taken: nighttime injection? Yes No as needed? Yes No
Delivery System: Injected/Syringe Injected/Pen Pump

NUTRITION (We **cannot** accommodate all dietary needs**):**

Special Dietary Needs: ____Yes ____No If yes, please specify_____
___Celiac Disease (Diagnosed only) ___Gluten-Free (IBS or Crohnôs) ___No Dairy (Lactose-Free)
___Vegetarian ___Vegan ___No Wheat (Gluten sensitivity)
___No Eggs ___No Pork ___No Red Meat ___No Poultry ___No Seafood
Special Needs/Problems: _____
FoodAllergies:_____
What reaction occurs if this food is eaten? __stomachache __vomits __hives/rash
__trouble breathing (requires epi-pen) ___other _____
Meal Plan followed? ____Yes ____No Is camper knowledgeable about this meal plan? ____Yes ____No
If yes, provide the following:

___Total calories: Number of meals: Number of snacks:
___Total carbohydrates: Breakfast carbs Lunch carbs: Dinner carbs:
___Is food measured? ____Yes ____No Weighed? ___ Estimated?___

EXERCISE:

P.E. at school: yes ____ no ____ (why not: _____) Time of day:_____
Times/week_____Problems:_____
Other Exercise: _____Team Sports:_____
Degree & Frequency of exercise (circle): None Light Moderate Heavy _____Times/wk
Hypoglycemia after exercise?____Yes ____No If yes, how severe and how soon after?_____

HEALTH HISTORY:

Medical Insurance Please provide a copy of insurance card in case of emergency or complete this information:
Name of Plan:_____Policy or Group Number_____
Does camper have any medical or psychological conditions (include any which are currently well controlled) (Y/N)___
Specifically, does your child have any of the following problems?

Convulsive Disorders?	____Yes ____No	Hyperactivity?	____Yes ____No
Diabetes?	____Yes ____No	Heart Disease?	____Yes ____No
Fainting?	____Yes ____No	Bedwetting?	____Yes ____No
Discipline Problems?	____Yes ____No	Sleepwalking?	____Yes ____No
Constipation?	____Yes ____No	Learning Disability?	____Yes ____No
Depression?	____Yes ____No	Obsessive Compulsive Disorder?	____Yes ____No
Attention Deficit Disorder?	____Yes ____No		

If yes to any of the above questions, explain here:
_____
_____
Has camper been hospitalized for any reason (medical or psychological)? ____Yes ____No
(please give dates and reason)_____
_____

ALLERGIES (including any food, medicine, animals, insects)
YOU MUST PROVIDE EPI PEN OR OTHER ALLERGY MEDICATIONS TO THE CAMP
1. _____ 2. _____ 3. _____
Reactions*: _____
**Reactions include: Severe total body reaction (anaphylaxis); shock; skin problems (hives, redness, blistering, itchy skin, swelling); breathing problems (wheeze, cough, chest tightness); mouth problems (swollen lips, rash, tongue swelling, itchy); throat problems (swollen, itchy, scratchy); eye problems (swollen, itchy, watery); nose problems (itchy, runny, stuffy, sneezing); intestinal problems (abdominal pain, vomiting, diarrhea); behavior/sleep problems (stimulation, hyper, strange behavior, sleepiness, trouble sleeping)*

Was emergency treatment needed for any of the reactions above (e.g. 911, ER visit, Urgent Care, EpiPen)? __Yes __No
If so explain:_____

Has your child had the following illnesses?
Measles? ____Yes ____No Rubella? ____Yes ____No
Chicken Pox? ____Yes ____No Mumps? ____Yes ____No
Date of most recent tetanus booster: _____
DPT, Polio and MMR immunizations up-to-date? ____Yes ____No

Females: Has camper menstruated? ____Yes ____No Next due date: _____
Is history normal? _____ Does camper have severe menstrual cramps? ____Yes ____No

MEDICATIONS (requires medication in pharmacy labeled container, including inhalers):
Rx: _____ Dose: _____ Reason: _____
Rx: _____ Dose: _____ Reason: _____
Rx: _____ Dose: _____ Reason: _____
VITAMINS or Supplements (must be in original container)
Name:_____Dose:_____Reason:_____

Please indicate if the following over-the-counter medications are authorized for administration during camp as needed
(DOSAGE WILL BE BASED ON INSTRUCTIONS LISTED ON THE PACKAGING OR BOTTLE ONLY)
__Pepto Bismul __Tylenol ___ Ibuprofen ___Tums or Rolaids ___Chloraseptic or throat lozengers
__Robitussin __Neosporin ointment ___Benadryl ___Hydrocortisone cream

BLOOD GLUCOSE TESTING: Does camper check blood glucose? (Y/N)____ If yes, what times?_____
Usual Blood Sugars for:
AM _____ NOON_____PM_____BEDTIME_____

HYPOGLYCEMIA: Does camper experience any of these symptoms weekly or more often? (Y/N)
___ If yes, check all that apply.
Symptoms: ____headache ____dizziness ____twitching ____fatigue
____irritability ____nausea ____shaking ____hunger ____pale
other _____
Can your child tell when their sugar is low? _____

Please check appropriate box for each question.	Need Improvement¹	Satisfactory²	Mastered³
Blood Sugar Testing **___N/A** Uses proper technique when checking blood sugar.			
Tests blood sugar at required time.			
Is able to correctly interpret blood sugar results.			
Injections/Pump Use **___N/A** Rotates injection sites appropriately.			
Able to correctly draw up insulin or give bolus.			
Able to give injections or change pump infusion site independently.			
Able to use advanced pump features (if has an insulin pump)			

Food Habits Makes appropriate food and drink choices.			
Able to accurately count carbohydrates or serving size			

Please describe the following about your child**:**

- Favorite Interests: _____
- Special needs, comfort items, routine_____
- Bedtime/sleep habits (light, heavy, sleepwalking, nightmares, etc.): _____
- Recent stressful events we should know about: _____
- What does your child do when he/she is mad, sad, or upset?: _____

Please tell us about your child... (please include a separate sheet of paper if you require additional space)

- What behavior(s), attitudes, etc. are typical/atypical? _____
- What type of instruction does your child respond to best? _____
- Does your child have any special fears, emotional, or behavioral problems? _____

IN CASE OF EMERGENCY

Whom can we contact during camp session?_____

Relation: _____ Phone (_____)_____ ( )_____

WHERE WILL PARENT BE DURING CAMP?_____Phone: ( )_____

PARENT'S AUTHORIZATION

PARTICIPATION AND EMERGENCY TREATMENT WAIVER

In consideration for being allowed to register and participate in Lions Diabetes Camp, as parent/guardian I hereby release the Camp, its Incorporators, Physicians, Board Members, Officers, Employees, Agents, Independent Contractors and Volunteer Workers from any liability for injuries which are sustained during the camp, **including any necessary transportation**. The child herein described has permission to engage in all scheduled activities except as noted by the physician or parent/guardian. I hereby give permission to the camp staff to initiate and provide any necessary treatments, including transporting to the nearest certified emergency facility. If hospitalization is required, the child is to be referred to an appropriate physician and all treatments will be at my expense.

I hereby grant permission to, and request and authorize all physicians, nurses and hospitals and their authorized employees and designees to perform routine diagnostic procedures and render emergency medical care deemed necessary for my child (ward).

PHOTOGRAPHY, VIDEO AND PROMOTIONAL RELEASE

I do hereby acknowledge and authorize Lions Diabetes Camp to take and use photographs, video and written comments of or by my child for promotional and informational materials. Further, I agree to release and discharge Lions Diabetes Camp and its sponsors from any and all liability in connection with the use of such photographs, videos and written comments of or by my child.

PERSONAL PROPERTY

I understand the Camp in no way is responsible for any personal article or item of property upon the conclusion of any camp session and that unnecessary valuables are not to be brought to camp.

RELEASE FOR TRANSPORT HOME

At the conclusion of camp, the Camp Staff may release my child to myself or to the individual(s) designated below. Under no circumstances will your child be released to anyone not specified by you. Picture ID may be required.

Name _____ Relationship to child _____ Phone (_____) _____
Please Print

Name _____ Relationship to child _____ Phone (_____) _____
Please Print

_____ _____/_____/_____ Phone (_____) _____
Signature of Parent or Guardian Date

CAMPER CODE OF CONDUCT

(Please review with your child)

It is our hope that everyone that participates in our program will have a positive experience that will last a lifetime. To help everyone get the most out of their camp experience, we have set up a list of ground rules to help parents and children understand what we expect at camp. We recognize the special needs of our campers and will as much as possible; individualize the rules according to the needs and abilities of each camper.

Camp has four basic rules that we explain to the children and also post in the cabins. We have these rules so that everyone can be assured of a positive experience.

- **Respect yourself, others and property.** This means abusiveness toward others or using inappropriate language, fighting, stealing, etc. It also covers property damage, graffiti or vandalism. Respect yourself, refers to keeping your things picked up, personal hygiene and taking your medication on time.

- **Participate in camp activities.** It is campôs responsibility to know where all the campers are at all times. We ask campers to be at all activities unless excused by staff. Campers cannot be left alone in their cabin.

- **Follow directions.** There are a lot of fun things to do at camp but every activity has rules so we can operate the activity safely and appropriately. We ask the campers to follow staff direction during these activities.
- **No put-downs.** Examples of this would include teasing, name-calling, racial slurs or inappropriate practical jokes.

If we do have a problem with inappropriate behavior, we have a camper behavior response policy. The counselor will start by giving the child a warning, then a time-out with an explanation and discussion on what is causing the problem. If the counselor needs help, a behavioral specialist or the designated healthcare team supervisor on site will work with the child to help avoid further problems. We will also call home to find out if the parents have any suggestions on ways to deter the inappropriate behavior. As a last resort, we may need to send a child home. Sometimes in the case of severe homesickness or if misbehavior could cause immediate harm to themselves or others, we reserve the right to immediately ask that the child be removed from camp.

It is our hope that each child will go home with great memories of camp. These rules are designed to protect the camperôs experience so that one unruly child wonôt ruin the experience for the rest. If you have any questions or comments, please feel free to call. It is our mission to provide a quality experience for everyone.

I understand and accept that my child must abide by the Camper Code of Conduct

_____
Parentôs Signature

I agree to abide by the Camper Code of Conduct _____ _____
Camperôs Signature Date

REVIEWED BY CAMP MEDICAL PERSONNEL _____

LIONS DIABETES CAMP MEDICAL HISTORY AND PHYSICAL EXAMINATION - *to be completed by physician*

Child's name _____ Birthdate_____ Height ____ Weight _____ B/P ____

IMPORTANT NOTE TO PHYSICIAN: The information requested in this form is extremely important to the applicantôs health and safety during participation at Camp. In most cases the level of activity will be higher than normal and the daily routine will be different. Camp has a health center on site staffed by camp nurses; however, we are able to provide only routine, basic health care. Critical care medical facilities are one hour away. It is crucial therefore, that care be taken in thoroughly completing this form. Thank you for your assistance in this important matter.

Date form completed _____/____/_____

Date of last physical exam _____/____/_____

Immunization Dates (indicate date of last vaccine given):
DT/DTap/DTP_____ Polio _____.
MMR _____ Chicken Pox _____.

Please circle Yes (Y) or No (N)

1. Is this patient under regular care? **Y / N**_____
2. Does the Camp Healthcare team need to be aware of any of the following:
   a. Known medical problems? **Y / N**_____
   b. Known behavioral or psychological issues? **Y / N**_____
   c. Foods that must be completely eliminated from this camperôs diet? **Y / N**_____
   d. Prescribed meal plan or dietary restrictions ? **Y / N**_____
   e. Other allergy or sensitivity problems? **Y / N**_____
   f. Specific medication issues? **Y / N**_____
   g. Treatments you prefer **not** be used at camp? **Y / N**_____
   h. Restrictions/limitations on participation in any camp activities? **Y / N**_____

   Please explain any ñyesò answers (please be specific) _____

MEDICATIONS

DRUG NAME (include if it is an inhaler, nebulizer or pill)	STRENGTH	ROUTE	DOSAGE	FREQUENCY

ALLERGY INFORMATION

Is this child allergic to any: MEDICATION?__Yes __ No \\\FOODS? __ Yes __ No \\\ANIMALS or INSECTS?__ Yes __ No

Does Camper have a current (non-expired) prescription for an EpiPen? ___Yes ___No (must provide their own at camp)

ALLEGEN	Reaction (be specific)	Age of Last Reaction

HEALTHCARE PROVDER'S AUTHORIZATION

I have examined the above camp applicant. My signature below indicates that I believe this patient is able to participate in an active camp program.

_____ _____
Healthcare Provider Signature — Printed Name of Healthcare Provider

_____ (_____) _____
Clinic or Office — Telephone

_____ _____
Street Address — City — State — Zip Code

_____ Would you volunteer at camp? ____Y ____N
Date