Office Phone: 540-224-4360
Fax: 540-344-0120

COVER PAGE

In order to reserve your space, COMPLETED forms and payment in full (or request for financial assistance) must be received NO LATER THAN Wednesday, May 6th, 2026.

Space is limited - applicants will be waitlisted if their age group is full.

Forms to be completed:

☐Registration Form ☐Permission Form ☐Camper Pick-up Form

☐Medication Form ☐Medical History ☐Financial Assistance (optional)

PAYMENT OPTIONS:

- Credit or debit card to Carilion Direct by phone at **540-266-6000**
  OR online: https://cvent.me/wlmPzL
- OR check made payable to **Carilion Camp Too Sweet**

Financial assistance is available to those who qualify - see pages 11-13.

Completed registration information MUST be sent via one of the following methods:

EMAIL:
CampTooSweet@carilionclinic.org
Kate Jones, Camp Too Sweet Director

MAIL:
Carilion Camp Too Sweet
1231 S. Jefferson St.
Roanoke, VA 24016

FAX:
540-344-0120
Attn: Camp Too Sweet

Fee:
Residential Camp (5 days, 4 nights): $450 per child
(Includes all meals, lodging, activities, and T-shirts)

Day Camp (5 days): $275 per child
(Includes lunches, daytime activities, and T-shirts)

REGISTRATION FORM

Child's Name: _____ Preferred Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City: _____ State: _____Zip Code: _____

Gender: _____ Race/ethnicity: _____

School Grade (2026-2027 school year): _____ Age as of July 6th 2026: _____

This will be camper's _____ year at Camp Too Sweet.

Camper will be attending: _____ Day Camp _____Residential (overnight) Camp

Cabin Mate Requests (for residential camp): _____
While careful consideration is given to each cabin request, the final decision rests with the camp administration. We will try to honor dual requests if both campers request each other to be in the same cabin, and if their age and gender allow.

T-shirt size:

Youth S: _____ Youth M: _____ Youth L: _____ Youth XL: _____

Adult S: _____ Adult M: _____ Adult L: _____ Adult XL: _____

Parent/Guardian Information

Primary Contact: Parent or Guardian Name: _____

Best Daytime Phone Number: _____ Other Phone Number: _____

Preferred E-mail Address: _____

Secondary Contact: Parent or Guardian Name: _____

Best Daytime Phone Number: _____ Other Phone Number: _____

Preferred E-mail Address: _____

Emergency Contact: (Person to contact if parent or guardian cannot be reached in the event of an emergency)

#1_____
Name Phone Number Relation to Camper

#2_____
Name Phone Number Relation to Camper

Insurance Information:

_____
Insurance Company Name Policy Number

PERMISSION FORM

WAIVER TO BE SIGNED BY PARTICIPANT(S) AND PARENT/GUARDIAN:
I, the undersigned, do hereby agree to participate in or allow the individual named herein to participate in the aforementioned activity. I assume all risk and liability that may arise from my or my child's involvement, transportation to and from, and participation in this activity. I understand that this program carries the possibility of physical injury and may involve physical activity that may be strenuous and there are risks inherent in this recreational activity. With regard to the activity to which this form applies, nothing shall be construed to grant an expressed or implied warranty of safety. I further understand that Camp Bethel and Carilion Camp Too Sweet and its officers, agents, and volunteers are not liable for any injury that may result from the negligence of persons conducting this program. Carilion Camp Too Sweet recommends that participants secure adequate medical insurance to cover any injury that may arise from participation in recreation programs.

PERMISSION TO USE NAME OR PICTURE
In accordance with section 8.01-40 of the Code of Virginia, I hereby give permission to be photographed during this activity and give the department permission to use or distribute such photographs and identification.
Must circle YES or NO: **YES** **NO**

PERMISSION TO TREAT AND TRANSPORTATION AUTHORIZATION
I hereby give permission to the camp to provide routine health care, over the counter medications, administer prescribed medication and seek emergency medical treatment including the ordering of x-rays or routine tests. I give permission to the camp to arrange necessary medical related transportation for my child. Examples of over the counter medications used, but not limited to:

Benadryl	Anti-Diarrhea	Acetaminophen	Sting-Eze	Stool Softener
Neosporin	Cold Compress	Betadine	Iodine	Ibuprofen

Please list any medication that may ***NOT*** be given: _____

Camper Dismissal: Campers possessing weapons, alcoholic beverages, fire building materials or illegal drugs will be expelled from camp immediately without a refund. Campers who are exceedingly disruptive, destructive or a danger to themselves or others will be expelled without a refund.

Parent's and Camper's Agreement
Safety is paramount at Camp Too Sweet. All reasonable precautions and safety procedures will be undertaken. Participants must be aware that there are inherent risks, beyond human control, associated with the types of activities offered. I understand that each individual's behavior and attitude is critical to the success of the camp. Therefore, if in the judgment of the staff, my behavior or attitude endangers the welfare of the group or myself, I will be sent home without refund. I will arrive at Camp Bethel prepared, both mentally and physically, to display a positive and respectful attitude to my fellow group members, to participate fully in all aspects of the program, and to adhere to Camp Bethel's rules and policies.

I/We have read and understand the registration information and agree to abide by those policies.

_____
Camper Name **Date**

_____
Parent/Guardian Signature **Date**

Camper Pick-Up Form

For the protection of your child, we require that the following form be completed and returned with the registration documents. Please list the names of those who are eligible to pick up your child including your names as parents or guardian. These names will be used for camper pick-up and will also be used to verify any claims made by anyone who comes to pick up a camper for any reason throughout the week. Also, if there is anyone you are concerned may attempt to pick up your child against your will, please list him or her as ineligible below. Camp Bethel will only release a camper to those listed as eligible, and we will notify the parent or guardian of any attempts made to pick up a camper by anyone listed as ineligible.

Camper's Name: _____

Persons Eligible for Camper Pick-Up:

Name: _____

Name: _____

Name: _____

Persons NOT Eligible for Camper Pick-Up:

Name: _____

Name: _____

Name of Parent or Guardian: _____

Phone number::_____

Monday Check-in Signature: _____ **Date:** _____

Friday Check-out Signature: _____ **Date:** _____

MEDICATION FORM

Camper's Name: _____ **DOB:** _____**DIABETES TYPE:** ☐**1** ☐ **2**

CAMPER ON INSULIN INJECTIONS:

Long-acting insulin type: (check one)

- □ Basaglar
- □ Lantus
- □ Semglee
- □ Toujeo
- □ Tresiba
- □ Other: _____

Long-acting insulin dose: _____ units
Long-acting insulin time of injection: _____ AM_____PM

Rapid-acting insulin type: (check one)

- □ Fiasp
- □ Humalog
- □ Lyumjev
- □ Novolog
- □ Other: _____

Does your pen administer ½ units? □Yes□ No

Daytime blood sugar target: _____
Daytime correction factor / sensitivity: _____
Nighttime blood sugar target: _____
Nighttime correction factor / sensitivity: _____

Insulin to carbohydrate ratio **OR** insulin units per meal/snack:
Breakfast: _____
Lunch:_____
Dinner: _____
Snacks: _____

AND

Correction Scale for High Blood Sugar:

_____ units if BG _____
_____ units if BG _____
_____ units if BG _____
_____ units if BG _____
_____ units if BG _____

_____ units if BG _____
_____ units if BG _____
_____ units if BG _____
_____ units if BG _____
_____ units if BG _____

Can child give own injections?
□ YES □ NO

Can child determine correct amount of insulin?
□ YES □ NO

Does your child use continuous glucose monitor (CGM): ☐YES ☐NO

Can they change their own sensor? ☐YES ☐NO

CGM brand & model:

- □ Dexcom G6
- □ Dexcom G7
- □ Dexcom 15 day
- □ Freestyle Libre 2 Plus
- □ Freestyle Libre 3 Plus
- □ Minimed Instinct
- □ Other: _____

CELL PHONES ARE NOT ALLOWED AT CAMP.
Does your child have a reader or receiver they can use while at camp? ☐YES ☐NO

MEDICATION FORM

Camper's Name: _____ **DOB:** _____ **DIABETES TYPE:** ☐1 ☐ 2

CAMPER ON INSULIN PUMP:

Insulin Pump Brand & Model: (check one)

- ☐ Twiist
- ☐ Omnipod 5
- ☐ Tandem t:slim with Control IQ
- ☐ Tandem Mobi
- ☐ Medtronic MiniMed 770G
- ☐ Medtronic MiniMed 780G
- ☐ Beta Bionics iLet
- ☐ Other: _____

Insulin Type: (check one)	**Basal Rates**: (time – units)	**Insulin/carbohydrate ratio (1 unit/carb grams)**
☐ Fiasp	12 AM to _____ _____ units	12 AM to _____ _____ g
☐ Humalog	_____ to _____ _____ units	_____ to _____ _____ g
☐ Lyumjev	_____ to _____ _____ units	_____ to _____ _____ g
☐ Novolog	_____ to _____ _____ units	_____ to _____ _____ g
☐ Other:_____	_____ to _____ _____ units	_____ to _____ _____ g
	_____ to _____ _____ units	_____ to _____ _____ g

Insulin infusion set information:

Type of infusion set: _____
Cannula Length: _____
Tubing Length: _____
Frequency of site changes: _____
Preferred sites: _____
Cartridge fill amount: _____

Daytime blood sugar target: _____
Daytime correction factor / sensitivity: _____
Nighttime blood sugar target: _____
Nighttime correction factor / sensitivity: _____

Do you ever give more or less insulin than the pump recommends?
☐ Yes ☐ No

Do you ever give more insulin than the max dose?
☐ Yes ☐ No

Do you use the extended bolus feature?
☐ Yes ☐ No

Do you use the temp basal rate feature?
☐Yes ☐ No

Do you use exercise mode?
☐Yes ☐ No

Do you use sleep mode?
☐Yes ☐ No

Can your child change their own pump site/infusion set?
☐Yes ☐ No

PLEASE NOTE: We will review your child's pump settings at camp check-in. If your child decides to take a pump break and go back on injections for any reason prior to camp, or changes to a different pump prior to camp, please let us know immediately.

Does your child use continuous glucose monitor (CGM): ☐YES ☐NO
Can they change their own sensor? ☐YES ☐NO

CGM brand & model:

- ☐ Dexcom G6
- ☐ Dexcom G7
- ☐ Dexcom 15 day
- ☐ Freestyle Libre 2 Plus
- ☐ Freestyle Libre 3 Plus
- ☐ Minimed Instinct
- ☐ Other: _____

CELL PHONES ARE NOT ALLOWED AT CAMP.

Can you see the blood sugar data on the pump? ☐YES ☐ NO

If NO, do you have a reader or receiver? ☐YES ☐ NO

Camper's Name: _____ **DOB:** _____

MEDICATION FORM CONTINUED:

Other medications:

Medication (include oral or non-insulin injectable diabetes medications)	Dosage	When Given (time of day or as needed)

Note: ALL MEDICATION MUST BE IN THE ORIGINAL CONTAINER AND BE PROPERLY LABELED. ALL MEDICATION WILL BE STORED ON SITE AND ADMINISTERED BY THE CAMP STAFF. THE MEDICATION ADMINISTRATION FORM MUST BE COMPLETELY FILLED OUT. PLEASE LIST ALL MEDICATIONS. If your child takes liquid medications, please remember to include the medication spoon.

I/We authorize the personnel of Carilion Clinic's Camp Too Sweet Diabetes Camp to administer listed medication and treatment to my child during camp as per my/our child's physician's instructions as listed above.

Camper's Name: _____ **DOB:** _____

Parent/Guardian Signature: _____ **Date:** _____

Physician name: _____

Physician address: _____

Physician phone number: _____

All medication (prescription/over the counter) needs to be packaged and labeled in the following manner:

- Place medication (in its original container/packaging) in a zip lock bag. Enclose instructions on how and when to administer. If this is prescription medication, make sure directions from the doctor are enclosed or printed on the container.
- Be sure to indicate proper storage of the medication (i.e. refrigeration).
- Only send enough medication for the length of camp.
- For multiple medications: enclose each medication in a separate zip lock bag with a separate instruction sheet.
- **For Campers with pumps: YOU MUST BRING YOUR OWN PUMP SUPPLIES. (DOUBLE THE AMOUNT YOU THINK YOU WILL NEED.)**
- **IF YOUR CONTINUOUS GLUCOSE MONITOR (CGM) IS NOT INTEGRATED WITH YOUR PUMP, YOU WILL NEED TO BRING YOUR DEXCOM RECEIVER OR LIBRE READER**
- **IF YOU DO NOT HAVE A DEXCOM RECEIVER OR LIBRE READER, LET US KNOW.**

_____

Self-management goals (if any) for camp: _____

_____

Additional comments or things med staff should be aware of: _____

_____

CAMP TOO SWEET RELEASE TO PARTICIPATE IN CAMP ACTIVITIES

TO BE COMPLETED & SIGNED BY LICENSED PHYSICIAN

Camper's Name: _____ **DOB:** _____

The above named camper was examined on the following date: _____/_____/_____

The camper is being treated for the following condition(s) other than diabetes:

_____

_____

Is there any information about this child's diabetes care which would be helpful for camp staff?

_____

_____

I certify this child is physically fit to participate in all the activities of "Camp Too Sweet" diabetes camp being co-sponsored by Carilion Clinic and Camp Bethel.

Provider full name (please print): _____

Street Address: _____

City, State, Zip: _____

Telephone #: _____

Provider Signature: _____ **Date:** ____/_____/_____

MEDICAL HISTORY

This form is to be completed in its entirety by parent/guardian. Campers will not be able to attend camp without this completed form.

Camper Name: _____ Age as of July 6th 2026: _____ Date of Birth: _____

Form completed by: _____ Relationship to Camper: _____

Height: _____Weight: _____ Gender: _____

Are this child's immunizations up to date? ☐YES ☐NO

Physician who treats child's diabetes: _____

Physician's Complete Address: _____

Physician's telephone number: (_____) _____

a. How long has the child had diabetes? _____ He/she was_____ years old at diagnosis.

b. Can child check their own blood sugar? ☐YES ☐NO

c. Please describe your child's recent blood glucose range: _____

_____

d. How often does your child have low blood sugar (hypoglycemia)?

☐almost daily ☐once a week ☐once a month ☐every few months ☐seldom or never

Is there a pattern to the low blood sugars in relation to time, food, or activity?

_____

_____

How do you recognize a low blood sugar in your child? What does he or she usually do or look like?

_____

_____

Does your child recognize when their blood sugar is low?

☐Always ☐Usually ☐Sometimes ☐Rarely

Have any blood sugars been low enough to need paramedic, glucagon emergency kit, emergency room or hospital care? ☐YES ☐NO If yes, please describe when and what happened:

_____

_____

At home, how have you been treating low blood glucose?

_____

e. Please describe how this child acts when his/her sugar is too high, and how often this occurs:

_____

Have any blood sugars been high enough to need paramedic, emergency room, or hospital care?

☐YES ☐NO If yes, please describe when and what happened:

_____

_____

f. This child's usual level of activity is: ☐high ☐average for age ☐not very active

g. Please describe any behavioral or psychological concerns or recent family, school or emotional problems that the camp staff should know about:

_____

_____

h. Have there been any diabetes-related emergencies or hospitalizations, besides high or low blood sugars?

☐YES ☐NO If yes, please describe:

_____

_____

i. What was the child's last Hemoglobin A1C (or Glycohemoglobin)? _____%
Date of the test: _____/_____/_____

j. Other health problems, past or present _____

k. List any physical restrictions or activity limitations_____

_____

l. List any allergies (medication, environment, etc.) and describe reactions and management of the reaction:

_____

m. List any food allergies / restrictions: _____

	Yes	No	Comments
Has menstruation started yet?			☐ N/A
Does this child wet the bed?			
Does this child wear glasses or contact lenses?			☐Glasses ☐Contacts
Can the child swim?			Level:
Ever had an injury or sickness related to cold or hot weather?			
Allergic to bee sting or other insect bites?			Reaction: _____ EpiPen: ☐YES ☐NO
Does the child have asthma?			Carry an inhaler ☐YES ☐NO
Any past injuries?			Describe:
Any surgeries?			Describe:
Tetanus Shot?			Date of last shot ____/____/_____

Camp Too Sweet Financial Assistance Policy/Application – OPTIONAL

I. Financial assistance is available to cover some or all Camp Too Sweet fees. There are no guarantees that financial assistance will be provided – **applicants must meet eligibility criteria on page 13 AND provide supporting documentation (W-2 and 1040 tax documents for 2025).** If in doubt regarding your eligibility, please apply as we have various means of obtaining financial assistance for those who need it.

II. **Financial assistance is based on need and will only be awarded after our receipt and eligibility review of all completed financial assistance forms and requested documents within the application deadline of Wednesday, May 6th.** Eligibility criteria includes meeting 400% *or less* of the federal poverty guidelines in which case full financial assistance will be provided. If you do not meet eligibility criteria based on these guidelines, but have extenuating circumstances, please elaborate on your situation and provide any relevant supportive documentation. (i.e. severance letter, etc.) All awarded funds are non-transferable, and there is no financial/monetary compensation for any unused funds.

III. Financial assistance is made possible through grants as well as contributions from individuals, businesses, foundations and civic groups. If you are interested in contributing to the camp program, please contact Camp Too Sweet at 540-224-4360.

IV. General Information

Name of camper: _____ Date of Birth: ____/____/_____

Age as of July 6th 2026: _____ Gender: _____ Grade (2026-2027 school year): ____

Address of camper: _____

City: _____ State: _____ Zip: _____

Best Daytime Phone # for Parent/Guardian: _____

V. Family Information

Child lives with: ☐ both parents ☐ Mother ☐ Father ☐ Grandparent(s) ☐ other

Number of siblings living in the home: ____

Total number of people (children & adults) living in the home: ____

Describe in detail any special family circumstances:

_____

_____

Name of **First** Parent/Guardian with whom camper lives _____

Relation to camper: _____

Occupation: _____Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Employer phone: _____ Parent email: _____

Name of **Second** Parent/Guardian with whom camper lives _____

Relation to camper: _____

Occupation: _____Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Employer phone: _____ Parent email: _____

VI. Reason for financial assistance

Describe how the camper would benefit from camp: (attach additional sheet if necessary)

_____

_____

VII. Financial Information

Total Annual Household Income:

Annual gross income from father/guardian's employment (before taxes) $ _____

Annual gross income from mother/guardian's employment (before taxes) $_____

Check other sources of income below. Indicate total annual income from these sources.

□ AFDC	$ _____
□ SSI	$ _____
□ Social Security	$ _____
□ Unemployment	$ _____
□ Pension	$ _____
□ Family	$ _____
□ Other (describe)	$ _____
Total Gross Annual Income	$ _____

Supporting documents to verify income (2025 tax documents: W-2 and 1040) must be attached to this application.

Please read the following information carefully:

All information in this application is for the purpose of obtaining financial assistance support and will be kept confidential. You have my permission to verify income or expense information provided.

I understand that notification of financial assistance awards will be sent by mail to address of primary contact listed on page 2 of this application.

_____

Signature of Parent/Guardian **Date**

Effective Date: January 2026

Federal Poverty Guidelines (400% of the federal poverty level)

FAMILY SIZE	
1	$63,840
2	$86,560
3	$109,280
4	$132,000
5	$154,720
6	$177,440
7	$200,160
8	$222,880
EACH ADDITIONAL FAMILY MEMBER	+$22,720