

COVER PAGE

In order to reserve your space, COMPLETED forms and payment in full must be received NO LATER THAN Friday, May 11, 2018.

Applications received after this date will be placed on a waiting list.

Forms to be completed:

- Registration Form Permission Form Camper Pick-up Form
 Medication Form Medical History Financial Assistance (optional)

PLEASE INCLUDE YOUR PAYMENT FOR ALL PARTICIPANTS

AND return with your check made payable to **Carilion Clinic**;

OR you may pay via credit or debit card to Carilion Direct

By phone at **540-266-6000**;

Or online: <http://www.cvent.com/d/rgqnty>

Completed registration information must still be sent via one of the methods below. Financial assistance is available to those who qualify.

Email:

kastahl@carilionclinic.org
Kate Jones, RD, CDE
Camp Too Sweet Director

Mail:

Carilion Camp Too Sweet
1030 S. Jefferson St.
Suite G101
Roanoke, VA 24016

Fax:

540-224-4357

Attn: Camp Too Sweet Registration

Fees:

Residential Camp (5 days, 4 nights): \$400 per child
(Includes all meals, lodging, activities, and T-shirts)

Day Camp (5 days): \$240 per child
(Includes lunches, daytime activities, and T-shirts)

REGISTRATION FORM

Child's Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Gender: Male ___ Female ___ School Grade (Fall 2018): _____ Age (as of 7/9/18): _____

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

Registering for: Residential Camp Day 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: _____

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

#3 _____
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 |
| Neosporin | Cold Compress | Betadine | Iodine |

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: _____ TYPE: 1 2

CAMPER ON INJECTIONS:

CAMPER ON INSULIN PUMP:

| Injection Time/Units/ Insulin Type: | Insulin Pump Basal Rates: |
|--|--|
| Time/ Units Insulin Type | From 12 AM to = Units |
| Time/ Units Insulin Type | From to = Units |
| Time/ Units Insulin Type | From to = Units |
| Time/ Units Insulin Type | From to = Units |
| | From to = Units |
| Correction Scale for High Blood Sugar: | Correction Scale |
| units if BG _____ units if BG _____ | Daytime blood sugar target: _____ |
| units if BG _____ units if BG _____ | Correction factor: _____ |
| units if BG _____ units if BG _____ | Nighttime blood sugar target: _____ |
| units if BG _____ units if BG _____ | Correction factor: _____ |
| units if BG _____ units if BG _____ | |
| Insulin/carbohydrate ratio: | Insulin/carbohydrate ratio: |
| Breakfast: _____ | Breakfast: _____ |
| Lunch: _____ | Lunch: _____ |
| Dinner: _____ | Dinner: _____ |
| Snacks: _____ | Snacks: _____ |
| Can child give own injections? <input type="checkbox"/> YES <input type="checkbox"/> NO | Pump brand & model: _____ |
| Can child determine correct amount of insulin: <input type="checkbox"/> YES <input type="checkbox"/> NO | Type of insulin used in pump: _____ |
| Daytime blood sugar target: _____ | Type of infusion set: _____ |
| Correction factor: _____ | Cannula length: _____ |
| Nighttime blood sugar target: _____ | Tubing length: _____ |
| Correction factor: _____ | Can child self-insert infusion set? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | Frequency of site changes: _____ |
| | Preferred sites: _____ |
| | Cartridge fill amount: _____ |

Continuous glucose monitor: YES NO If yes, brand & model: _____

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

Special insulin issues: _____

Is your child currently taking any other medication(s) YES NO

Special Instructions: _____

| Medication (include oral 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.)**
-

CAMP TOO SWEET RELEASE TO PARTICIPATE IN CAMP ACTIVITIES

TO BE COMPLETED & SIGNED BY LICENSED PHYSICIAN

Camper's Name: _____

I have examined the above named camper on **date:** ____/____/____

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.

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?

Physician full name (please print) _____

Address: _____

City, State, Zip: _____ **Telephone:** _____

Physician's Signature: _____ **Date:** ____/____/____

If completed by a Nurse or PA, please sign: _____

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: _____ Date of Birth _____

Form completed by: _____ Relationship to Camper: _____

Height: _____ Weight: _____ Gender: Female ___ Male ___

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 Do they need help? YES NO

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

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

every few hours almost daily once a week

every few months once a month 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?

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 exercise 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 restriction or activity limitations _____

l. List any **allergies** and describe reactions and management of the reaction: _____

m. List any food restrictions: _____

| | Yes | No | Comments |
|--|-----|----|--|
| Has menstruation started yet? | | | |
| Does this child wet the bed? | | | |
| Does this child wear glasses or contact lenses? | | | <input type="checkbox"/> Glasses <input type="checkbox"/> 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: <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Does the child have asthma? | | | Carry an inhaler <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Any past injuries? | | | Describe: |
| Any surgeries? | | | Describe: |
| Tetanus Shot? | | | Date of last shot ____/____/____ |

**Camp Too Sweet
Financial Assistance Policy/Application**

- 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 below. To find out if you are eligible, please reference the chart on page 12 of this application. 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 May 11th. Eligibility criteria includes meeting 250% *or less* of the federal poverty guidelines in which case full or partial 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 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 ___ Male Female Grade in Fall of 2018 _____

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 (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.

- | | |
|---|----------|
| <input type="checkbox"/> AFDC | \$ _____ |
| <input type="checkbox"/> SSI | \$ _____ |
| <input type="checkbox"/> Social Security | \$ _____ |
| <input type="checkbox"/> Unemployment | \$ _____ |
| <input type="checkbox"/> Pension | \$ _____ |
| <input type="checkbox"/> Family | \$ _____ |
| <input type="checkbox"/> Other (describe) | \$ _____ |
| Total Gross Annual Income | \$ _____ |

Supporting documents to verify income (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 2018

| Federal Poverty Guidelines | 150% | 250% |
|--------------------------------------|-----------------|------------------|
| FAMILY SIZE | | |
| 1 | \$18,210 | \$30,350 |
| 2 | \$24,690 | \$41,150 |
| 3 | \$31,170 | \$51,950 |
| 4 | \$37,650 | \$62,750 |
| 5 | \$44,130 | \$73,550 |
| 6 | \$50,610 | \$84,350 |
| 7 | \$57,090 | \$95,150 |
| 8 | \$63,570 | \$105,950 |
| EACH ADDITIONAL FAMILY MEMBER | +\$6,480 | +\$10,800 |