Office Phone: 540-224-4360 Fax: 540-224-4357

COVER PAGE

In order to reserve your space, COMPLETED forms and payment in full must be received NO LATER THAN Wednesday, May 17, 2017.
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: 540-266-6000 or 800-422-8482. 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): $390 per child
(Includes all meals, lodging, activities, and T-shirts)

Day Camp (5 days): $230 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 2017): __________ Age as of 7/17/17: ________

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: Breakfast: ______________ Lunch: _________________ Dinner: _________________ Snacks:_________________	**Insulin/carbohydrate ratio:** Breakfast: _________________ Lunch:_____________________ Dinner:_____________________ Snacks:
Can child give own injections? ☐YES ☐NO	Pump brand/Model:________________________ Type of insulin used in pump:________________
Can child determine correct amount of insulin: ☐YES ☐NO	Type of infusion set:_________________ Cannula length:______________________ Tubing length: ______________________
Daytime blood sugar target:______________ **Correction factor**:_____________________ Nighttime blood sugar target:_____________ **Correction factor**:_____________________	Can child self-insert infusion set? ☐YES ☐NO
	Frequency of site change/locations:
	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 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?			**☐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

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 17th. 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 2017 ____

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.

- □ AFDC $ ________________
- □ SSI $ ________________
- □ Social Security $ ________________
- □ Unemployment $ ________________
- □ Pension $ ________________
- □ Family $ ________________
- □ 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 2017

Federal Poverty Guidelines	**150%**	**250%**
FAMILY SIZE		
1	**$18,090**	**$30,150**
2	**$24,360**	**$40,600**
3	**$30,630**	**$51,050**
4	**$36,900**	**$61,500**
5	**$43,170**	**$71,950**
6	**$49,440**	**$82,400**
7	**$55,710**	**$92,850**
8	**$61,980**	**$103,300**
EACH ADDITIONAL FAMILY MEMBER	**+$6,270**	**+$10,450**