LIONS DIABETES CAMP AT LAKE MCCUMBER

Sponsored by the Lions District 4-C1 Health Foundation

Camper and Parent/Guardian General Information Form

Camper Information

Camper's Name: (Last)_____ (First)_____

Mailing Address: _____
(Street) (Apt.)

_____
(City) (State) (Zip)

Phone: (_____)_____ E-mail: _____

Sex: M____ F____ Age: _____ Shirt Size S M L, S M L 1XL 2XL 3XL 4XL
(Youth) (Adult) (Circle one)

Birth date: ___/___/_____ Camper's Nickname (optional): _____
(Choose a "fun" nickname)

Grade next fall?_____ School:_____

Attended Camp before? Y____ N____ Year(s)?_____

Special Dietary Needs:

_____Gluten Free

_____Allergic to the following foods:_____

_____Other special dietary needs:_____

_____Vegetarian (Please do not check unless you plan to eat only vegetarian meals, as we have to pay extra even if you don't eat them.)

PARENTS/GUARDIANS INFORMATION:

Mother's Name: _____

Address: _____

Home phone: (____)_____ Work phone: (____)_____

Father's Name: _____

Address: _____

Home phone: (____)_____ Work phone: (____)_____

Step Parent's Name:_____

Address: _____

Home phone: (____)_____ Work phone: (____)_____

Camper lives with: Mother____ Father____ Guardian____ Step Parent___ Other___

(specify)_____

Who has full legal custody? _____

EMERGENCY CONTACT NAMES

IN CASE OF EMERGENCY, If parent cannot be located, the following person (relative or close friend) should be contacted. This person must have a telephone and be available to pick up the camper. ***They should reside at a different house than the camper.***

Name_____
Relationship_____
Address_____
City, State, Zip _____
Phone: Day_____**Evening**_____

TRANSPORTATION INFORMATION AND AUTHORIZATION

Occasionally parents are unable to transport their child to and from camp. We will attempt to put you in contact with another parent in your area as needed. *Completion of this section is optional, but we do have campers who need rides, so please help if you can*!

____ I would be willing to help transport a camper from my area if needed.

____ I am in need of assistance transporting my child. (Staff will follow up after your request has been processed. Please be patient.)

Signed: _____Date:_____
(Parent or guardian)

PUBLICITY RELEASE

Camper (name in full) _____
plans to attend the Lions Diabetes Camp at Lake McCumber. Attendance at camp is considered a publicity release and gives the Lions' Health Foundation the right to use pictures, quotes, etc. in marketing literature and for other Health Foundation purposes.

Signed: _____Date:_____
Parent(s) or Guardian(s)

AGREEMENT TO CAMP RULES

This form must be signed and returned with the application before registration can be completed.

The goal of the Lions and Lioness Clubs of District 4-C1 is to provide a very valuable experience to young persons with diabetes at Camp McCumber. The program is based on a strong commitment to a valuable, fun learning experience at camp. ***PLEASE*** read the following rules carefully and sign below. Your signatures below indicate you (camper and parent/guardian) have read the rules, understand them, and agree to observe them.

(Continued next page)

RULES FOR PERSONAL CONDUCT AT CAMP:

- Campers may not leave camp without the permission of the CAMP DIRECTOR.
- Campers will not destroy either camp or personal property and will be liable for damages.
- Campers will not intentionally physically or emotionally injure another person. This includes improper language (swearing, threatening), fighting and other incidents.
- Campers will not engage in any type of sexual or inappropriate contact.
- Campers will not SMOKE or possess any tobacco or smoking materials.
- Campers will not use or possess ALCOHOL or DRUGS. Campers may not keep any medications with them or in their cabins. All medications, even over-the-counter medications, must be kept in the infirmary or with the cabin nurse.

- Campers are allowed supervised use of cell phones for diabetes monitoring only. If you wish to take pictures, bring a camera, preferably disposable. No cell phone cameras.
- Campers who are in the PROXIMITY of someone who is breaking one of the above rules may also be dismissed from camp.
- DIABETES TESTING EQUIPMENT must be used properly and disposed of immediately in the designated area. Campers may not self-administer insulin independently. All insulin dosing must be done in collaboration with camper's cabin provider (MD, NP, PA, or CDE).

Campers must cooperate with all treatment of high and low blood sugar episodes, including consenting to nasal glucagon administration or mini-glucagon injection if recommended by provider. Refusal of recommended treatment is an automatic GO HOME.

No food can be kept in cabins due to pests.

NOTE: ***THERE ARE NO EXCEPTIONS TO THE ABOVE RULES, ANY CAMPER WHO DOES NOT FOLLOW THESE RULES: 1) WILL BE PROMPTLY DISMISSED FROM CAMP: 2) MUST HAVE PARENT OR GUARDIAN COME TO CAMP TO PICK THEM UP: 3) CAMP FEES WILL NOT BE REFUNDED: 4) RISKS LOSING THE PRIVILEGE OF RETURNING TO CAMP IN THE FUTURE.***

Camper also agrees to the "GO" program – upon first trouble incident (swearing, bickering, disobeying, loud music, etc.) camper gets a "G" and we call parents: upon second incident camper gets an "O" and must "GO" HOME. We contact camper's parents and they pick up camper.

CAMPER, PLEASE NOTE AND SIGN: I have read and understand the rules for attending camp and agree to abide by them:

Signature: _____Date: _____

(Camper's signature)

PARENT OR GUARDIAN – PLEASE NOTE AND SIGN: As Parent or guardian, you are expected to help enforce the rules set by the camp committee.

I have read and understand the rules and will help enforce them. I agree to pick up my child from camp early if he/she breaks this contract. I further agree that if I am unable to pick up my child that I have previously arranged to have the following person pick up my child from camp (required if you may not be able to pick up your child):

Pickup Person's Name _____ Phone _____

Relationship _____

Parent/Guardian Signature: _____Date: _____

FINANCIAL INFORMATION

The Lions Health Foundation of 4-C1, a non-profit service organization whose purpose is to provide an educational camping experience to help youth with diabetes, sponsors Camp McCumber for children with diabetes. The fee for seven days at camp is $500. Camper fees are applied to the expenses associated with the camp facility, medical supplies, food, kitchen staff, and educational and recreational activities. Please make checks payable to: ***Lions Health Foundation, District 4-C1 and indicate on the check that it is for "Diabetes Camp." Send to: Sue Kerr 3250 Cowgill Lane, Redding, Ca 96003***

GENERAL PAYMENT INFORMATION

NOTE: This section MUST be completed or the application will be returned to you!!

We are asking for a **$50.00** or greater deposit to accompany this application and the remaining **$450** to be paid when your child arrives at camp. Your deposit will be returned if your child cannot attend camp (and we are notified in writing by June 1st), or in the unlikely event that Camp is cancelled.

_____I am enclosing $_____ (Min. **$50.00**) deposit and will pay the $_____ balance (**Total $500**) when my child arrives at camp. Check #_____

_____I paid a deposit of $_____ (Min. **$50.00**) online and will pay the $_____ balance (**Total $500**) when my child arrives at camp.

_____ _____
Signature of Parent(s) or Guardian(s) Date

If you cannot afford the full cost of sending your child to camp, fill out the section below and we will help you find a campership for him/her.

CAMPERSHIP PAYMENT INFORMATION

Fill out the information below if you cannot afford the total fee and are requesting a campership:

I can contribute $_____ towards the cost of my child going to camp. I have included or paid online $_____ (deposit) and will pay $_____ (balance) when my child arrives at camp. I am requesting a scholarship for the remaining amount $_____ of the campership.

_____ _____
Signature of Parent(s) or Guardian(s) Date

PARENT/GUARDIAN PERMISSION FORM

Camper's Name: _____ Age _____
Diabetes onset age: _____
Answer each question on a scale of: 1 = Always, to 5 = Never.

	Always…….				Never
My child takes responsibility for his/her diabetes care	1	2	3	4	5
My child adjusts easily to new situations	1	2	3	4	5
My child has fears and/or nightmares	1	2	3	4	5
My child wets the bed	1	2	3	4	5
My child relates well to others	1	2	3	4	5
My child has trouble following rules	1	2	3	4	5
My child has trouble learning	1	2	3	4	5

Any activity restrictions? Yes____No____If yes, please explain_____
_____
_____

Have there been any significant changes in your child's life in the past year (i.e.. Move, Divorce, Marriage, Death) or is there any other information that may be helpful? Yes_____ No_____
If Yes, please explain:_____

PARENT/GUARDIAN PERMISSION

_____ (Camper's Name) has my permission to attend Diabetes Camp at Camp McCumber. Permission is given to representatives of Lions of District 4-C1 to render customary health care including adjustments to insulin and diet, as needed based on the decisions of the medical staff. I understand that any part of my child's medical records may be used for medical care and related purposes. If a needle used by my child sticks anyone at camp, I/we hereby consent to routine blood testing of my child under the direction of the camp physician and authorize such by signing this form. In case of emergency, I authorize the camp medical physician or staff to obtain necessary medical care.

Signed: _____ Date: _____
(Parent or Guardian)

Relationship to Camper: _____

Send completed application to:

Maggie Robeson
3733 N. Hwy. 3
Etna , CA 96027

Medical Provider (Physician/Mid-Level Practitioner) Form

We must receive this completed form, signed by the medical provider, with the completed application.

INSULIN DELIVERY METHOD AND DOSING PLAN: (Complete one section PUMP or MDI)

INSULIN PUMP - BRAND/MODEL: _____

Camper's Name_____

Date of Birth: _____ Age at diagnosis with Type 1 Diabetes: _____

Age camper will be on the first day of camp: _____ Most recent A1c: _____ Date: _____

BG MONITORING METHOD: **CGM / FSBG** (CIRCLE ONE OR BOTH)

BRAND NAME(S): _____

BASAL SETTINGS:

Time	Basal Rate (units/hr)
12:00 am	

BOLUS SETTINGS:

Insulin to Carb Ratios:

Time	Carb Ratio
12:00 am	

Insulin Sensitivity/Correction

Factor(s)

Time	Sensitivity/Correction

12_am_____

_____

_____

_____

_____

___

Blood Glucose Target(s):

Time	Target Range (mg/dl)
12:00am	

Active Insulin Time / Insulin on Board time ____ hours

Medical Provider (Physician/Mid-Level Practitioner) Form

We must receive this completed form, signed by the medical provider, with the completed application.

INSULIN DELIVERY METHOD AND DOSING PLAN: (Complete one section PUMP or MDI)

MULTIPLE DAILY INJECTIONS (MDI)

Camper's Name_____

Date of Birth: _____ Age at diagnosis with Type 1 Diabetes: _____

Age camper will be on the first day of camp: _____ Most recent A1c: _____ Date: _____

BG MONITORING METHOD: **CGM / FSBG** (CIRCLE ONE OR BOTH)

BRAND NAME(S): _____

Please specify insulin PENS or VIAL with the type/brand.

Long-acting Insulin type / brand: _____
Dose: _____ (units) Time of Day: _____ (AM/PM)
Dose: _____ (units) Time of Day: _____ (AM/PM)

Rapid-Acting Insulin type / brand: _____

Carbohydrate Coverage:

Breakfast _____unit for every ____ grams carb

Lunch _____unit for every _____ grams carb

Dinner _____ unit for every _____ grams carb

Morning snack _____unit for every ____ grams carb

Afternoon snack _____unit for every ____ grams carb

Bedtime snack _____unit for every ____ grams carb

Blood Sugar Correction:

Breakfast ____ unit for every ____ mg/dl over ____

Lunch ____ unit for every ____ mg/dl over ____

Dinner ____ unit for every ____ mg/dl over ____

Morning snack ____ unit for every ____ mg/dl over____

Afternoon snack ____ unit for every ____ mg/dl over____

Bedtime snack ____ unit for every ____ mg/dl over____

Does this child:

Give insulin her/himself? Yes____ No____

Draw up his/her insulin independently? Yes ____ No ____

Test her/his blood sugar independently? Yes____ No ____

Medical Provider Form, Continued

Camper's Name_____ Date of Birth _____

Height _____ Weight _____ BP _____/_____ Pulse_____

Allergies to foods, medications, insects, etc.: _____

Does this child have/need an epinephrine auto-injector? Yes___ No___

Medical History: (circle all that apply)

Hypothyroidism Celiac Disease Atopic Dermatitis/Eczema Asthma Allergies/Hay fever

Depression/Anxiety Attention Deficit-Hyperactivity Disorder Nocturnal Bedwetting Night Terrors

Other (specify) _____

Medications (other than insulin):_____
_____
_____
_____
_____

Recent Hospitalization/Reason? _____

Immunizations: Up to date for age? Yes ___ No ___

Date of last Tetanus vaccination: _____ Date of last MMR vaccine: _____
Date of last Varicella vaccination: _____ or date of Chicken Pox disease _____
Date of last Flu vaccine: _____
Has child been vaccinated for COVID-19 (number of injections) _____Brand _____

OR
PLEASE PROVIDE A COPY OF THE CHILDS MOST RECENT IMMUNIZATION/VACCINATION RECORDS

Any Activity Restrictions? _____

Other Important Information relevant to camp?

_____
_____

MEDICAL HEALTH CARE PROVIDER PERMISSION

I approve of Camp McCumber activities for this camper (includes hiking, active sports, supervised lake activities):

Name of Physician/Health Care Provider (please print): _____

Signature: _____ Date: _____

Address: _____

Phone Number: _____ Fax Number: _____