

**CAMPER APPLICATION  
CAMP SEALE HARRIS & CAMP SUGAR FALLS 2010**

**ADMISSION CRITERIA**

Child has diabetes. If not diabetic, may apply to attend <u>Camp Sugar Falls</u> with a sibling or friend having diabetes.	Child is capable of learning diabetes management skills in a group setting.
Child is in the age range birth - 17 yrs (Camp Seale Harris).	Child has no condition that poses a direct threat to self or others.
Child is in the age range 6 – 15 yrs (Camp Sugar Falls).	Child is cooperative in the management of his/her diabetes.
Child is in the age range 15 - 17 yrs (Adventure Camp).	

**INSTRUCTIONS**

1. All applicants complete and return the Summer Camp Application, Camper Interesting Facts, Health History, Diabetes Medication Dosing Schedule (if applicable), Insulin Pump Information (if applicable), Diabetes Care, Diet Information, Insurance Information and Acknowledgement of Receipt of Privacy Practices. All applicants submit a copy of the current Immunization Record with these forms.
2. Complete and bring the Blood Sugar/Insulin Record to Camp Registration.
3. Your Physician must complete and sign the Medical Examination Form. Have him/her complete it, then return it and all other forms (with the exception of the Blood Sugar/Insulin Record) at least 30 days prior to the opening day of your child's camp session.

Name \_\_\_\_\_ New Camper? \_\_\_\_\_

Prior Years as a SDES (CSH/CSF/ADV, etc) participant \_\_\_\_\_

Please Check Session Attending    \_\_\_ CSH Summer Family Camp    \_\_\_ CSH Senior Camp  
   \_\_\_ CSH Junior Camp     \_\_\_ Adventure Camp  
   \_\_\_ Camp Sugar Falls - City \_\_\_\_\_

We **MUST** have telephone numbers for emergency use where parent(s) or guardian(s) can be reached for the entire camp session. The telephone number of a relative or friend who can be reached if parent(s) or guardian(s) are unavailable is also very helpful.

Name 1 \_\_\_\_\_ Home # (    ) \_\_\_\_\_

Work # (    ) \_\_\_\_\_ Other # (    ) \_\_\_\_\_

Name 2 \_\_\_\_\_ Home # (    ) \_\_\_\_\_

Work # (    ) \_\_\_\_\_ Other # (    ) \_\_\_\_\_

Name 3 \_\_\_\_\_ Home # (    ) \_\_\_\_\_

Work # (    ) \_\_\_\_\_ Other # (    ) \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone # (    ) \_\_\_\_\_

Diabetes Physician \_\_\_\_\_ Phone # (    ) \_\_\_\_\_

Dentist/Orthodontist \_\_\_\_\_ Phone # (    ) \_\_\_\_\_

Social Worker \_\_\_\_\_ Phone # (    ) \_\_\_\_\_

Psychologist/  
Psychiatrist \_\_\_\_\_ Phone # (    ) \_\_\_\_\_

Who will pick up your child at the end of camp? \_\_\_\_\_

Relationship \_\_\_\_\_

PERMISSIONS

Child's Name \_\_\_\_\_

Southeastern Diabetes Education Services operates education, recreation, and support programs for children with diabetes and their families. Programs are provided through collaborative partnerships of Southeastern Diabetes Education Services (SDES) with one or more of the following collaborating partner(s): Camp ASCCA, Camp Grace, Lakeshore Foundation, Nemours Clinic and others. Information that you provide as a participant of this program is made available to each collaborating partner of the specific event that you or your family attend.

*Parent/Guardian please read each item below, **place your initial** beside each item you grant approval for, and sign at the bottom indicating your permission.*

Southeastern Diabetes Education Services publishes "Program Directories" that are distributed to the campers, parent/guardian if attending a family activity, volunteers, and paid staff of SDES who participated in the specific program. The directory includes the following information: Camper/Family Name, Home Address, Parent(s) Email and Parent(s) Home Phone.

\_\_\_\_\_ I give permission for the above named person, and family if participating in a Family Program, named  
(initial) on this form to be included in the "Program Directory" of the program that he/she/we participated in.

Southeastern Diabetes Education Services participates in non-invasive research studies that are designed to study diabetes and that have promise to increase the knowledge base of diabetes management.

\_\_\_\_\_ I give permission for statistical information regarding the person(s) named on this form to be provided to  
(initial) Southeastern Diabetes Education Services' approved researchers who are studying diabetes and/or SDES program(s). Name(s) and personal identifying information will not be disclosed.

Southeastern Diabetes Education Services (SDES) and its collaborating Partner(s) uses/publishes photographs, video and audio recordings taken at their activities, including but not limited to Camp Seale Harris, Camp Sugar Falls, Adventure Camp, and community activities. Photographs, video, and audio recordings are used to communicate about the mission, programs, and activities of SDES and of our collaborating partner(s) to the SDES family, the general public, organizations, foundations, civic organizations, and others who may have interest in supporting the mission of SDES and/or its collaborating partner(s). Participants consent for all purposes to the use or publication of photographs, video and audio recordings of the participants (with or without the use of the participant's name) by SDES and its collaborating partner(s) in all forms of media and in all manners, including trade, display, advertising, editorial, art and exhibition. In giving this consent, participant releases Southeastern Diabetes Education Services and its collaborating partners from liability for any violation of any personal and/or proprietary right that participant may have in connection with such use.

ATTENDEE NAMES - Please list everyone who will be attending. Also, will you provide the additional requested information to help us plan for programs that you attend, and to enable us to generate statistical reports – not including your name(s) - regarding those whom we serve please?

NAME	Date of Birth	Gender	Race	Diabetes Y/N	County/State (if different)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

## CONSENT TO PARTICIPATE AND AUTHORIZATIONS

I hereby permit \_\_\_\_\_ to attend and participate in all programs and activities provided by Southeastern Diabetes Education Services, and their affiliated program partners, hereinafter referred to as Camp, throughout the duration of his/her stay, with the exception of activities exempted on the Medical Examination Form.

I hereby authorize the Camp physician, or his/her authorized representative, to furnish or arrange for the furnishing of such medical and/or hospital care as above named camper might require during such time as he/she is at Camp. I hereby authorize Camp and/or hospital physicians, nurses, hospitals and their authorized personnel employed, contracted, paid on a fee basis or volunteer to perform all treatments and procedures as deemed necessary; this medical care may include, but not be limited to, examinations, treatments, immunizations, injections, anesthesia, surgery, and other procedures.

I hereby authorize the release of medical records possessed by Camp and/or the hospital to physicians, nurses, hospitals and their authorized personnel for the performance of treatments and procedures as deemed necessary upon my child. I understand that Camp will make a diligent effort to notify me if a medical emergency occurs and that I will receive a report of the treatment(s) and/or medication(s) given to the above named camper.

The payment of medical costs incurred for treatment of medical conditions, illnesses, or accidents while participating in Southeastern Diabetes Education Services programs including but not limited to the purchase of any medications/prescriptions, hospitalizations and/or other medical care secured for the treatment of my child, that are not covered by the camper's personal insurance, and the cost of such personal insurance coverage, is the responsibility of the camper and his/her parent/guardian. I understand that my insurance company may be billed for medical services provided to my child by medical personnel while he/she is in attendance at Camp.

In following OSHA guidelines of tissue and body fluid contamination, should an exposure of blood or other potentially infectious bodily fluids occur, including needle sticks, Camp obtains blood testing of individuals involved in the exposure. In the event my child is a party to an exposure of blood or other potentially infectious bodily fluids, including a needle stick, either as the individual receiving the exposure, or the person whose blood or potentially infectious bodily fluids were exposed to another, I hereby authorize Camp to have blood testing conducted on my child and do hereby grant approval for the results of such testing to be made available to Camp and to the party(s) involved in the exposure.

Occasionally a Camp Seale Harris child experiences difficulty with homesickness. In order to minimize the effect of homesickness, letters to your child are encouraged. Our experience has taught us that direct communication between the child and parent often creates increased anxiety for the child. Therefore, the child is not allowed to make or receive phone calls while at Camp. This also means that children are not permitted to have cell phones at camp. Camp staff will make a diligent effort to comfort your child in the case of homesickness. You will be notified if homesickness persists. You may call and speak with the medical staff if you have concerns or questions during your child's stay.

Southeastern Diabetes Education Services is not responsible for personal items lost, misplaced, etc.

Camp Staff reserves the right to send a camper home if illness or other significant reason so dictates.

The undersigned hereby acknowledges that the activities, environs and programs of Southeastern Diabetes Education Services and its collaborating partner(s) are potentially dangerous and there is risk of physical injury. In consideration for allowing my child/family/self to participate in the activities and/or programs of Southeastern Diabetes Education Services, and use their premises, or the premises of their affiliated program partners, I hereby release and forever discharge Southeastern Diabetes Education Services, Camp ASCCA, Camp Grace, Lakeshore Foundation, Nemours Clinic, and their affiliated program partners, their agents, officers, directors, employees, and volunteers, and all other persons liable or claimed to be liable, and agree to indemnify and hold harmless from any and all claims, demands, damages, suits or injuries whatsoever arising from or related to my attendance, or the attendance of my child/family, at activities and/or programs of Southeastern Diabetes Education Service and their collaborating partner(s).

Furthermore, the undersigned, parent/legal guardian if person(s) named on this form is/are minor children, acknowledge that they have read, understood, agree with and consent to the above policies of Southeastern Diabetes Education Services and their collaborating partner(s).

**TYPE/PRINT** Name of Parent/Legal Guardian \_\_\_\_\_

**SIGNATURE** of Parent/Legal Guardian \_\_\_\_\_ **DATE** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## DISCIPLINE POLICY

In order to insure a safe, healthful environment for all campers, the following rules will apply and will be strictly enforced.

1. Campers will be cooperative in the management of their diabetes, including but not limited to blood glucose testing, insulin injections or insulin pump therapy, dietary management, and exercise.
2. Campers will follow instructions and/or directives of staff having supervisory responsibility over them.
3. Campers will remain in designated areas with their cabin group, unless instructed by supervisory staff to go to another location.
4. Campers will refrain from abusive behavior toward others or self.
5. Campers will refrain from the use of abusive or profane language.
6. Campers will refrain from taking or abusing items/supplies from other campers, the staff, or the camp facility, and will refrain from abuse of the camp facilities.
7. The possession of electronic communication devices including but not limited to cell phones, Bluetooths, Blackberry's, pagers, etc. by campers will not be permitted.
8. SDES encourages the involvement of campers in all activities and their interaction with fellow campers and staff.
9. At Camp Sugar Falls electronic games, CD players, and media storage devices such as IPODS are strongly discouraged. At Camp Seale Harris electronic games, CD players, and media storage devices such as IPODS may only be used during rest time, but are to be turned off at all other times. Devices having sound should have headphones. Such devices may not include non-family friendly media such as profanity, pornographic images, or other distasteful media.
10. SDES is not responsible for personal items lost, misplaced, etc.
11. Possession of weapons will not be permitted.
12. Use of alcohol (including beer and wine), tobacco products and/or illegal drugs will not be permitted.

*Infraction of rules will constitute grounds for immediate dismissal from camp.*

Southeastern Diabetes Education Services (Camp Seale Harris & Camp Sugar Falls) reserve the right to inspect any campers' luggage, backpack(s), purse(s), or other personal belongings at any time during the program period.

**Parent/Guardian:** The undersigned, as parents or legal guardians of the above named minor child, acknowledge that they have read, understood, agree with and consent to the above discipline policy of Southeastern Diabetes Education Services.

### TYPE/PRINT

SIGNATURE of Camper \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Please Print Name of Parent/Legal Guardian \_\_\_\_\_

SIGNATURE of Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Interesting Facts about YOU!!!  
CAMP SEALE HARRIS 2010



1. What is your full name and how old are you? \_\_\_\_\_ years
2. Do you have a nickname that you would like to be called at camp? \_\_\_\_\_
3. Who lives at home with you? \_\_\_\_\_
4. What is your favorite food? \_\_\_\_\_
5. What is your least favorite food? \_\_\_\_\_
6. What do you like to do for fun? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. What makes you happy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. What makes you sad? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. What makes you scared? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. What would you like to do at summer camp? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. Please tell us anything else that you would like us to know about you!  
\_\_\_\_\_  
\_\_\_\_\_

**DIABETES CARE ASSESSMENT  
CAMP SEALE HARRIS & CAMP SUGAR FALLS 2010**

Childs Name: \_\_\_\_\_ Present Age: \_\_\_\_\_

Type of Diabetes:  Type 1  Type 2

Date of Diabetes onset/diagnosis: \_\_\_\_ / \_\_\_\_

Please check if your child:

<input type="checkbox"/> Draws or Dials up Insulin for injection	<input type="checkbox"/> Has severe low blood sugar reactions	<input type="checkbox"/> Is able to treat high blood sugar levels	<input type="checkbox"/> Follows meal plan
<input type="checkbox"/> Rotates injection or infusion set locations	<input type="checkbox"/> Is often unaware of low blood sugar	<input type="checkbox"/> Is able to treat low blood sugar levels	<input type="checkbox"/> Adjusts nutrition for activity levels
<input type="checkbox"/> Gives insulin injection or changes pump site	<input type="checkbox"/> Has frequent high blood sugar levels	<input type="checkbox"/> Calculates insulin dosage for meals	<input type="checkbox"/> Adjusts insulin for activity levels
<input type="checkbox"/> Programs basal rates and pump settings	<input type="checkbox"/> Is generally aware of high blood sugar levels	<input type="checkbox"/> Calculates insulin dosage for correction	<input type="checkbox"/> Is able to adjust diet for sick days
<input type="checkbox"/> Checks Blood Sugar without assistance	<input type="checkbox"/> Checks urine for ketones	<input type="checkbox"/> Knows how to treat for ketones	<input type="checkbox"/> Adjusts insulin dosage for sick days

Please answer the following questions. Attach additional pages if necessary.

Are there concerns or problems with any of these areas?

<input type="checkbox"/> Accepting their Diabetes	<input type="checkbox"/> Understanding their Diabetes	<input type="checkbox"/> Controlling their Diabetes
<input type="checkbox"/> Sticking with their Meal Plan/Diet	<input type="checkbox"/> Keeping up with their Log Book	<input type="checkbox"/> Overall health and energy level
<input type="checkbox"/> Challenges with learning	<input type="checkbox"/> Getting along with Friends	<input type="checkbox"/> Getting along with Family

Please help us to understand your child so they can have a happy, safe and confidence-building camp experience. Describe any physical, social, emotional and/or psychological needs, and the techniques you find helpful in meeting these needs. Please include difficulties with diabetes management, challenges with eating, social concerns, behavioral concerns, significant learning disabilities, possibility of homesickness, etc.

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What you would like for your child to gain or learn by attending camp? \_\_\_\_\_

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What does your child say he/she would like to gain or learn by attending camp? \_\_\_\_\_

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You may write additional comments on the back or this page or attach additional sheets if needed.

**MEDICAL EXAMINATION FORM**  
**CAMP SEALE HARRIS & CAMP SUGAR FALLS 2010**  
*THE EXAMINATION TO BE COMPLETED BY A LICENSED  
PHYSICIAN WITHIN 120 DAYS OF PROGRAM ATTENDANCE*

<b>Date of Exam</b>  / /
--------------------------------

Childs Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_Type 1 Diabetes \_\_\_\_ Type 2 Diabetes, Insulin Requiring \_\_\_\_ Type 2 Diabetes, Non-Insulin Requiring  
Last Hgb A1C\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Micro ALB\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Last LDL\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Does the child have any physical condition(s) requiring restriction(s) on participation in the camp program? If so, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the child taking any current or on-going treatment(s) or medication(s)? If so, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EXAMINING PHYSICIANS STATEMENT**

I have examined this child and his/her medical history and find that he/she is able to attend Camp Seale Harris and/or Camp Sugar Falls and participate in the activities except as noted above. I understand that insulin dosages may be changed by the camp physician as required by glucose values.

Physicians \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Physicians \_\_\_\_\_  
Name (Please print or type)

Telephone (\_\_\_\_\_) \_\_\_\_\_

**HEALTH HISTORY**  
**CAMP SEALE HARRIS & CAMP SUGAR FALLS 2010**  
*TO BE COMPLETED BY PARENT/GUARDIAN*

<b>Date Completed</b> /   /
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Child's Name \_\_\_\_\_

Date of Birth    /    /

Height \_\_\_\_\_                      Weight \_\_\_\_\_

(Please CHECK and GIVE DATE for any of the following conditions your child has had.)

	Check	Date		Check	Date
Frequent Ear Infections	_____	_____	Asthma/Respiratory	_____	_____
Heart Defect/Disease	_____	_____	Chicken Pox	_____	_____
Seizures (Epilepsy)	_____	_____	Measles	_____	_____
Behavior Problems	_____	_____	German Measles	_____	_____
Bleeding/Clotting Disorders	_____	_____	Mumps	_____	_____
Kidney Disease	_____	_____	Bedwetting	_____	_____
Gastrointestinal Disorders	_____	_____	Orthopedic Problems	_____	_____
Eating Disorders	_____	_____	Hepatitis	_____	_____

**ALLERGIES**                      Check

Ivy Poisoning, Etc.            \_\_\_\_\_  
 Hay Fever                      \_\_\_\_\_  
 Insect Stings                 \_\_\_\_\_  
 Latex                              \_\_\_\_\_  
 (Such as Examination Gloves)

**DRUG, FOOD & OTHER ALLERGIES**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please respond to the following questions. Attach additional pages if necessary.**

What are the child's symptoms of allergic reaction(s)? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Does the child suffer from any current, recurring, or chronic medical condition(s) or any immuno compromising condition(s)? Please explain & specify medication(s) and/or treatment(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has the child had any surgeries, significant illnesses or injuries? Please explain, give dates and describe treatment(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Does the child have a history of diabetic ketoacidosis? \_\_\_\_\_    When? \_\_\_\_\_  
 Please explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has the child ever experienced a diabetes related seizure, hypoglycemia (low blood sugar) requiring intramuscular glucagon or intravenous glucose, or nocturnal hypoglycemia ? \_\_\_\_\_ When? \_\_\_\_\_

Please explain \_\_\_\_\_

Does the child have any other major diabetes related problems or special needs? \_\_\_\_\_

How many times in the past two years was the child hospitalized or treated at the Emergency Room due to diabetes?

When, and what was the reason(s) for the admission(s)? \_\_\_\_\_

How often does the child visit his/her pediatrician or family physician for care related to diabetes? \_\_\_\_\_

His/her usual exercise? \_\_\_\_\_

Any special restrictions or considerations while at camp? \_\_\_\_\_

Any special dietary considerations while at camp? \_\_\_\_\_

Is there anything about diabetes that you would like for us to try to teach your child while he/she is at camp? \_\_\_\_\_

**IMMUNIZATIONS - We are required to have a copy of your most recent immunization record. The Health Department updates your form periodically. You MUST provide us a copy of your child's current Immunization Record every year, even if you provided us this information the last time your child attended camp.**

**IMPORTANT: PARENTS MUST NOTIFY THE CAMP OFFICE IF THE CHILD IS EXPOSED TO OR DEVELOPS ANY INFECTIOUS OR COMMUNICABLE DISEASE, ILLNESS OR HEADLICE AND/OR RECEIVES TREATMENT FOR AN ACCIDENT OR INJURY AFTER RETURNING THE MEDICAL FORMS AND PRIOR TO REGISTERING FOR CAMP.**

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**DIABETES MEDICATION DOSING SCHEDULE  
CAMP SEALE HARRIS & CAMP SUGAR FALLS 2010**

To be completed by parent/guardian for campers taking insulin injections or oral medications.

(Campers using pumps, please complete Insulin Pump Form)

Name: \_\_\_\_\_

Is camper on tablets/pills for diabetes? If so, give name, dosage and time. \_\_\_\_\_

\_\_\_\_\_

Insulin Maker and Type of Insulin	# of Units Given	Time Given	Circle AM or PM
1. _____	_____	_____	AM PM
2. _____	_____	_____	AM PM
3. _____	_____	_____	AM PM
4. _____	_____	_____	AM PM
5. _____	_____	_____	AM PM
6. _____	_____	_____	AM PM

What is the child's targeted blood glucose? Daytime \_\_\_\_\_ Bedtime \_\_\_\_\_

Carbohydrate Counting. – If used please indicate how dosing is calculated.

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Supper \_\_\_\_\_

Snacks \_\_\_\_\_

If insulin for meals is calculated other than by carbohydrate ratio, Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OVER**

**Sliding Scale or Correction Factor for additional Insulin for high blood glucose.**

1. Sliding scale with \_\_\_\_\_ insulin. Please indicate correction in units below:

(Type of Insulin)

101-150    151-200    201-250    251-300    301-350    351-400    401-500    Over 500

\_\_\_\_\_

When is correction by sliding scale given? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**or**

2. Correction Factor

Supplemental insulin for blood glucose (BG) over \_\_\_\_\_ by this formula:

Blood Glucose Level \_\_\_\_\_

Minus Target Blood - \_\_\_\_\_ = \_\_\_\_\_ divided by \_\_\_\_\_ = \_\_\_\_\_ Units of \_\_\_\_\_  
Glucose (correction factor) (Type of Insulin)

Additional information we need to know concerning your child's insulin or medication:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SDES physicians prefer to minimize adjustments to insulin dosage and/or dietary intake. I understand that there is variability in activity during the camp session and that it may be necessary for the Medical Staff to adjust or alter the insulin dosage or diet for my child having diabetes while in attendance at camp. I hereby give consent for such adjustments.

*Please provide as much information as possible about your child's insulin treatment and adjusting insulin doses. This information is very useful to our physicians as they monitor the child's blood glucose levels and write insulin administration orders. Write on the back of this form or attach additional information if needed.*

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**INSULIN PUMP INFORMATION 2010**  
**CAMP SEALE HARRIS & CAMP SUGAR FALLS 2010**

Please complete and return this form if camper uses an Insulin Pump

Staff Use /      /
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Child's Name \_\_\_\_\_ Age \_\_\_\_\_

How long has child had diabetes? \_\_\_\_\_ How long has child been on pump? \_\_\_\_\_

Pump Type & Model \_\_\_\_\_ Pump Serial No. \_\_\_\_\_

Type of Infusion set \_\_\_\_\_ Cannula Size \_\_\_\_\_

Amount of insulin used to fill cannula \_\_\_\_\_ units. Site is changed every \_\_\_\_\_ days.

Type of Insulin used \_\_\_\_\_

List numbing agent if used and instructions. \_\_\_\_\_

\_\_\_\_\_

What is the child's targeted blood glucose? Daytime \_\_\_\_\_ Bedtime \_\_\_\_\_

List 24 hour basal rates:

Time \_\_\_\_\_ Rate \_\_\_\_\_      Time \_\_\_\_\_ Rate \_\_\_\_\_      Time \_\_\_\_\_ Rate \_\_\_\_\_

Time \_\_\_\_\_ Rate \_\_\_\_\_      Time \_\_\_\_\_ Rate \_\_\_\_\_      Time \_\_\_\_\_ Rate \_\_\_\_\_

Time \_\_\_\_\_ Rate \_\_\_\_\_      Time \_\_\_\_\_ Rate \_\_\_\_\_      Time \_\_\_\_\_ Rate \_\_\_\_\_

Does your child use or know how to use a temporary basal rate?      Yes \_\_\_\_\_ No \_\_\_\_\_

Check spaces below if your child needs help performing any of the following:

Site change \_\_\_\_\_ Filling Reservoir \_\_\_\_\_ Basal rate changes \_\_\_\_\_ Boluses for meals \_\_\_\_\_

Does your child wear a Continuous Glucose Monitoring System? Yes \_\_\_\_\_ No \_\_\_\_\_

**Carbohydrate Counting.** – If used please indicate how dosing is calculated.

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Supper \_\_\_\_\_

Snacks \_\_\_\_\_

If insulin for meals is calculated other than by carbohydrate ratio, Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Sliding Scale or Correction Factor** for additional Insulin for high blood glucose.

1. Sliding scale with \_\_\_\_\_ insulin. Please indicate correction in units below:

(Type of Insulin)

101-150    151-200    201-250    251-300    301-350    351-400    401-500    Over 500

\_\_\_\_\_

When is correction by sliding scale given? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**or**

2. Correction Factor

Supplemental insulin for blood glucose (BG) over \_\_\_\_\_ by this formula:

Blood Glucose Level \_\_\_\_\_

Minus Target Blood - \_\_\_\_\_ = \_\_\_\_\_ divided by \_\_\_\_\_ = \_\_\_\_\_ Units of \_\_\_\_\_

Glucose (correction factor) (Type of Insulin)

Please add any additional information you feel we need to know about your child and his/her use of the Insulin Pump.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SDES physicians prefer to minimize adjustments to insulin dosage and/or dietary intake. I understand that there is variability in activity during the camp session and that it may be necessary for the Medical Staff to adjust or alter the insulin dosage or diet for my child having diabetes while in attendance at camp. I hereby give consent for such adjustments.

*Please provide as much information as possible about your child's insulin treatment and adjusting insulin doses. This information is very useful to our physicians as they monitor the child's blood glucose levels and write insulin administration orders. Write on the back of this form or attach additional information if needed.*

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**SOUTHEASTERN DIABETES EDUCATION SERVICES  
CAMP SEALE HARRIS  
NUTRITION INFORMATION 2010**

Name \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender \_\_\_\_\_  
Age Diagnosed \_\_\_\_\_ Does the camper use an Insulin Pump? \_\_\_\_\_ What type(s) of insulin does the camper use? \_\_\_\_\_

1. The camper's meal plan/diet is by: \_\_\_Carbohydrate Counting \_\_\_Calorie \_\_\_ADA Exchange List.  
2. If known, please give the child's total daily number of carbohydrates \_\_\_\_\_.

2. Please CIRCLE the method used in preparing servings:  
Weighed      Measured      Gessed      Unlimited      Limit only sweets, sugar and starches

4. Please list examples of snacks if your child has them at:

Mid-Morning	Mid-Afternoon	Bedtime
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Are you satisfied with your meal plan/diet? \_\_\_\_\_ If not, why? \_\_ (Need more food? Less food?) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Please List food allergies:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Does your child have Celiac disease?      Yes \_\_\_\_\_ No \_\_\_\_\_

NOTE: We encourage campers learn to try new foods which they may not eat at home. This is often helpful when the camper returns home. Also, campers may eat more at camp since they are leading very active lives. When they return home, they may resume their prescribed diet, but we hope their eating habits will be greatly improved.

**SOUTHEASTERN DIABETES EDUCATION SERVICES  
CAMP SEALE HARRIS & CAMP SUGAR FALLS  
HEALTH INSURANCE INFORMATION 2010**

CAMP SESSION:    \_\_\_ Summer Family Camp    \_\_\_ Junior Camp    \_\_\_ Senior Camp  
                         \_\_\_ Adventure Camp    \_\_\_ Camp Sugar Falls

Camper Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Home Address \_\_\_\_\_ Gender \_\_\_\_\_  
City/State/Zip Code \_\_\_\_\_ Social Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Parent(s) or Guardian(s):**

Name _____	Name _____
Home Phone (____) _____	Home Phone (____) _____
Home Address _____	Home Address _____
City/State/Zip Code _____	City/State/Zip Code _____
Employer _____	Employer _____
Work Phone (____) _____	Work Phone (____) _____

**INSURANCE**

**Please attach a copy of your Insurance Card/Medicaid Card.** Also please attach completed, signed insurance forms and referrals/authorizations if they are necessary.

Insurance Co. Name \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

AL Medicaid Card # \_\_\_\_\_ Cardholder Name \_\_\_\_\_

Eligible for Medicaid? Yes \_\_\_\_\_ No \_\_\_\_\_ Dates From \_\_\_\_\_ To \_\_\_\_\_

Are you insured under ALABAMA CHILD CARING INSURANCE? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide policy # \_\_\_\_\_

Are you insured under ALL KIDS (Alabama Children's Health Insurance Program)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide policy # \_\_\_\_\_

Insurance Address for Claims:

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insurance Co. Telephone # (\_\_\_\_) \_\_\_\_\_

**INSURED'S AUTHORIZATION SIGNATURE**

I hereby authorize the release of any medical information necessary to process this claim and request payment of insurance benefits to the physician/provider who accepts assignment.

\_\_\_\_\_  
Signed (Parent/Guardian)

\_\_\_\_\_  
Date



**SOUTHEASTERN DIABETES EDUCATION SERVICES, INC.**  
**NOTICE OF PRIVACY PRACTICES**  
**Revised January 17, 2008**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Except as permitted or required by law, Southeastern Diabetes Education Services will not disclose personal health information. Southeastern Diabetes Education Services allows staff members to access personal health information to administer or provide health care or to perform their job duties. Staff members who misuse this information are subject to disciplinary action. We provide physical, electronic, and procedural safeguards to guard your health information.

We collect personal health information from the following sources:

- From you, the camper, camper parent/guardian or staff member. We may disclose health information about you to other health care personnel/health care providers who are involved in your health care.
- For payment. We may use and disclose your health information so that your Southeastern Diabetes Education Services may be billed to, and payment may be collected from you, an insurance company, or a third party.
- For health care operations. We may use and disclose health information about you for Southeastern Diabetes Education Services' operation, unless you provide us with alternative instructions. These uses and disclosures are necessary to run Southeastern Diabetes Education Services and make sure that you receive quality service.
- As required by law. We will disclose health information about you when required to do so by federal, state, or local law.
- To avert a serious threat to health or safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to prevent the threat.
- Public health risks. We may disclose health information about you for public health activities. These activities generally include the following: (1) to prevent or control disease, injury, or disability; (2) to report reactions to medication or problems with products; (3) to notify people of recalls of products that they may be using; (4) to notify a person who may have been exposed to a disease or may be at risk for contacting or spreading a disease or condition; and, (5) to notify the appropriate government authority if we believe a person has been the victim of abuse, neglect, or domestic violence (we will only make this disclosure if you agree or when required or authorized by law).
- For third party activities. We may disclose health information to a third party for regulatory activities and other activities authorized by law. These third party activities, which are necessary for the government and/or regulatory agencies to monitor the health system, include audits, investigations, and licensure.
- Lawsuits and disputes. If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court order or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.
- For Specific Government Functions. Southeastern Diabetes Education Services may disclose health information for the following specific government functions: (1) health information of military personnel, as required by military command authorities; (2) in response to a request from law enforcement, if certain conditions are satisfied; and (3) for national security reasons.

## WHEN SOUTHEASTERN DIABETES EDUCATION SERVICES MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION

Except as described in this Notice, Southeastern Diabetes Education Services will not use or disclose your health information without your written authorization. If you authorize Southeastern Diabetes Education Services to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

## YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

- The right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to your request.
- The right to inspect and copy your health information as long as Southeastern Diabetes Education Services maintains the health information. We may charge a fee to cover the costs of copying, mailing, labor, or other supplies necessary in fulfilling your request.
- The right to amend your health information that is incorrect or incomplete. Southeastern Diabetes Education Services is not required to amend health information that is accurate and correct.
- The right to receive an accounting or disclosure of your health information we have made after April 14, 2003. We are not required to account to you for disclosures made for treatment, payment, operations, disclosures to you or your parent/guardian, and for certain government functions.
- The right to request communications of your health information by alternative means or at alternative locations. You must state how or when you would like to be contacted. We will accommodate all reasonable requests.
- To receive a printed copy of the Southeastern Diabetes Education Services Notice of Privacy Practices.

If you would like to exercise one or more of these rights, contact Southeastern Diabetes Education Services. You may be required to submit a written request.

## CHANGES IN THIS NOTICE OF PRIVACY PRACTICES

Southeastern Diabetes Education Services reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. Any revised Notice will be posted at Southeastern Diabetes Education Services. Upon request, we will provide a revised Notice to you.

## FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have any questions or would like additional information about Southeastern Diabetes Education Services privacy practices, you may contact the Privacy Officer, Southeastern Diabetes Education Services, 500 Chase Park South, Suite 104, Hoover, AL 35244 or phone 1-205-402-0415 or fax 1-205-402-0416. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer at the above address or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

**ACKNOWLEDGEMENT OF RECEIPT OF  
SOUTHEASTERN DIABETES EDUCATION SERVICES, INC.  
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received the Southeastern Diabetes Education Services, Inc. Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Southeastern Diabetes Education Services is not required to agree to my requested restrictions, but if Southeastern Diabetes Education Services does agree, it is bound to abide by such restrictions.

Camper/Staff Name: \_\_\_\_\_

Relationship to  
Camper/Staff: \_\_\_\_\_  
(Parent, Guardian, Self)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

**OFFICE USE ONLY**

I attempted to obtain the camper/staff's signature in acknowledgement on the Southeastern Diabetes Education Services Notice of Privacy Practices, but was unable to do so as documented below:

Date	Name	Reason
_____	_____	_____