



Dear Parent/Guardian:

Thank you for your interest in Akron Children's Hospital Diabetes Camp, held at Camp Asbury in Hiram, OH, the week of June 17-21, 2024. It is hard to believe this is our 15th year of camp. Ages for eligible campers this year will be 9-14. Eligible patients must be 9 years old by June 17, 2024. The camp is only for patients with type 1 diabetes who are seen in our office.

CAMP REGISTRATION PACKET: please complete the following forms and mail them to the office

1. Camp application
2. Diabetes history
3. Health history
4. Food plan
5. Campership application (if applicable)
6. Activity and Medical Release Form
7. Behavior Agreement

Send completed packets to:
Center for Diabetes & Endocrinology: CAMP
Akron Children's
One Perkins Square, Akron OH 44308
Fax: 330-543-8489
Email: diabetescamp@akronchildrens.org

Please note that we are limiting camp to 60 participants. Selection will be based on the date that we receive your completed registration packet (the forms listed above). Your packet will not be considered complete until every form is received. Camp spots fill quickly! There will be a waiting list once we reach our maximum number of campers. **DEADLINE IS 4/26/24.**

CAMP FEE:

Camp will cost **\$300** per camper, due upon **acceptance** to camp. Please **DO NOT** send payment in at this time

CAMPERSHIPS:

We are the recipients of a large grant which allows us to provide full and partial camperships to eligible families. We invite you to apply for a campership as eligibility criteria are very generous! The attached campership application is used to determine eligibility along with the requested documentation. Please note that even if you receive a campership, you will be required to pay a minimum fee of **\$25** for camp.

TRANSPORTATION:

Transportation to and from camp will be the responsibility of the child's parent/guardian. Drop off will be on Monday June 17 in the afternoon and pick up will be Friday June 21 in the morning. Final arrival and pickup times will be provided to you as part of the camp acceptance packet.

DIABETES CAMP MEDICAL HISTORY FORM:

Please note there is a separate form that must be completed and signed by your child's pediatrician (NOT the endocrinologist). This form will need to be returned by **MAY 17, 2024**, to secure your child's spot at camp. A sports physical for the 2023-2024 school year is an acceptable substitute. If your child has not been seen by their pediatrician in the last year, please call and make an appointment now.

CAMP ACCEPTANCE:

We will notify you via email when we receive your packet. If you do not hear from us within 3 business days of sending your packet, please call the camp line at 330-543-2267. If you do not have a working email address, we will notify you via phone or mail. Camp acceptance information will be sent out at the end of April.

If you have any questions regarding camp, please feel free to contact us at 330-543-CAMP (2267).

Sincerely,

Katie Yovanovich BSN, RN, CDCES & Maggie Monroe BSN, RN Camp Directors
Lisa M. Davis MSN, APRN, CPNP & Stephanie L. Marszal MSN, APRN, CPNP
Camp Medical Directors



2024 Diabetes Camp Application

I prefer to receive my information regarding camp via:

- Mail
 Email

Add diabetescamp@akronchildrens.org to your list of approved addresses – prevents from going to Spam/Junk

Last Name		First	M.I.	Home Phone
Date of Birth	Age (at time of camp)		Gender	Grade in NEXT School Year
Street Address				County
City	State	Zip Code		Email Address
Parent/Guardian Name				Phone Number
Parent/Guardian Name				Phone Number
In an emergency, if parent/guardian cannot be reached, please call:				Phone Number
Name of Primary Care Health Provider (Pediatrician)				Phone Number
Name of Psychologist/Psychiatrist/Counselor/Therapist				Phone Number
Do we have permission to speak with your child's mental health/other health care providers?				<input type="checkbox"/> Yes <input type="checkbox"/> No
T-Shirt Size (check one)				Cabin Mate Request:
Child	S	M	L	_____ (We make every effort to accommodate special requests but cannot guarantee they will be honored)
Adult	S	M	L XL 2XL	

Insurance Information (please provide copies of front and back of all insurance cards)

Insurance Company	Name of Policy Holder
ID or Policy Number	Group Number

Please Note: All campers will receive a meter to use at camp. All blood glucose monitoring supplies and insulin will be provided to your child while they are at camp. Please do not bring these items with you.

If your child is on an insulin pump, please provide 3 infusion sets and reservoirs. If your child uses an inserting device, please provide that as well. If your child is on a CGM, please **do not** bring it to camp. **Only campers on an automated pump system will be allowed to wear one.** Children are checked frequently, including overnight, by trained medical professionals. If any questions or concerns, please contact us via the diabetescamp@akronchildrens.org.

Diabetes Information:

Date of diagnosis: _____ Most recent A1c: _____ Date: _____

Has your child ever had a severe low blood sugar (seizure, loss of consciousness, or other)?

Yes No

If yes, when, and how often? _____

Does your child use an insulin pump? Yes No If yes, which one? _____

What insulin does your child use (check all that apply): Novolog Humalog Admelog Fiasp

Tresiba Lantus Levemir Basaglar Other: _____

Camp Experience/History:

Has your child ever been away from home for more than two days? Yes No

Has your child ever been to a camp before? Yes No Where _____ How Long _____

Has your child ever been to another diabetes camp before? Yes No Where _____ How Long _____

He/she makes friends with other children (check all that apply): Own Age Younger Older

Medical Information:

Has your child been hospitalized (including psychiatric facilities)? Yes No

If yes, please explain (include reason and year): _____

Does your child have any other medical, physical, social, or emotional problems other than diabetes?

Yes No If yes, please specify: _____

Has your child ever been on a behavior modification plan or a formal disciplinary plan? Yes No

If yes, was he/she able to successfully adhere to it? Yes No

Please explain: _____

Has your child demonstrated any risk-taking behavior in relation to his/her diabetes, including but not limited to: intentionally omitting insulin, under blousing or over blousing? Yes No

If yes, please explain: _____

Does your child currently participate in Special Education Services? Yes No

If yes, please explain: _____

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

- | | |
|--|---|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Severe Low Blood Sugar _____ |
| <input type="checkbox"/> ADD/ADHD _____ | <input type="checkbox"/> Eating Disorder _____ |
| <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> Learning or Dev Disorder _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Problems Sleeping _____ |
| <input type="checkbox"/> Bedwetting _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Constipation _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> DKA _____ | |
| <input type="checkbox"/> Heart Disease _____ | |

Allergies

- Ivy Poisoning, Etc.
- Hay Fever
- Insect Stings
- Latex

Drug and Other Allergies

(Such as examination gloves)

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

Help us to understand your child so that he/she will have a happy, safe, confidence-building camp experience. Please include difficulties with **diabetes management, physical, emotional, and psychological needs, behavioral problems, eating problems, social concerns, possibility of homesickness**, etc., and the techniques you find useful in supporting your child. ***The more honest, open, and descriptive you can be, the better*** as this information is extremely important in helping us provide the ***best possible*** camp experience for your child and his/her camp peers. (Please attach another sheet if needed.)

Please list all medications (aside from insulin) that your child takes along with other information below:

Medication	Dosage	Time	Reason for taking medication

(Medications MUST BE sent in their original containers. Due to the volume of medications and insulin that must be distributed, we are asking that you NOT send vitamins and other nutritional supplements to camp.

What type of food plan does your child follow at home? Consistent Carbohydrate Insulin-to-Carb Ratio

Is your child on an insulin pump? Yes No

Does your child have celiac disease? Yes No

Does your child have any special dietary needs?

Food Allergies? _____

Food Avoidances? _____

Food Intolerances? _____

Carbohydrate Counting Chart						
(even if you use an insulin to carb ratio, please estimate the total number of carbs for meals - this will help our dietitians choose a carb plan for your child while they are at camp)						
Meal	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Grams of Carbohydrates						

Note: While at camp, diets may be altered to accommodate the increased energy needs often required because of more vigorous activity. Be assured that Registered Dietitians who work often with children and adolescents with diabetes will be making any changes that are necessary.

Wrist Band	Carbohydrate Meal Plan
Green	45, 60, 60
Orange	60, 60, 75
Blue	75, 75, 75
Purple	90, 90, 90
Pink	90, 105, 105



Camp Fee Assistance Application 2024

Child lives with: mother father both parents other _____

Number of children living in the home _____ Total number of people living in the home _____

Describe in detail any special family circumstances. (If you need more room, use back of page and write "over")

Name of First Parent/Guardian with whom camper lives _____

Relation to camper _____ Occupation _____

Employer Name _____

Employer Address _____

City _____ State _____ Zip _____

Employer Phone _____

Name of Second Parent/Guardian with whom camper lives _____

Relation to camper _____ Occupation _____

Employer Name _____

Employer Address _____

City _____ State _____ Zip _____

Employer Phone _____

Are you employed? No Yes \$ per month _____

Is your spouse employed? No Yes \$ per month _____

Do you or your spouse receive unemployment benefits? No Yes \$ per month _____

Are you receiving Social Security benefits? No Yes \$ per month _____

Are you receiving spousal support/alimony? No Yes \$ per month _____

Are you receiving child support? No Yes \$ per month _____

Are you receiving welfare benefits? No Yes \$ per month _____

Are you receiving food stamps? No Yes \$ per month _____

Are you receiving Veterans/Disability benefits? No Yes \$ per month _____

Are you receiving 401K/Retirement funds? No Yes \$ per month _____

Are you receiving any other forms of income? No Yes \$ per month _____

Total Monthly Household Income: _____

****You must attach a copy of the following: Most recent income tax return (IRS 1040); Two most current pay stubs; Other acceptable documentation to verify your annual earnings**

Please read the following information carefully:

All information in this application is true to the best of my knowledge. The information is to be used for the purpose of obtaining scholarship/campership support and will be kept confidential. You have my permission to verify income or expense information provided.

Signature of Parent/Guardian _____ Date: _____



DIABETES CAMP 2024

ACTIVITY PERMISSION

The staff of Akron Children’s Hospital Diabetes Camp has planned a full and active schedule for your child’s session. The activities that will be offered include: swimming, boating, archery, hiking, horseback riding and other athletic activities.

All campers, regardless of age, will be required to take a swim test at the beginning of camp. Please note, it will be up to the Akron Children’s Hospital Diabetes Camp staff discretion whether campers will be permitted to swim, depending on the weather and temperature of the water. Please check **one** of the following two boxes below:

I give permission for _____ to participate in all camp activities.
(Camper’s Name)

I give permission for _____ to participate in all activities **except** (please list):
(Camper’s Name)

I/We understand that although Akron Children’s Hospital staff has taken reasonable steps to provide my child with appropriate training, equipment and skilled staff for his/her camp experience, I acknowledge that some inherent risks cannot be eliminated without destroying the unique character of these activities. I understand that participation in camp is entirely voluntary and understand that unanticipated dangers might arise during the camp session experience. In consideration of participation in the camp activities, on behalf of the camper and myself, I hereby release, indemnify and hold harmless Akron Children’s Hospital and its employees, agents and volunteers from any and all liability and claim for loss arising from bodily injuries or damage to personal property resulting from the camper’s involvement and participation in the camp, including, but not limited to injury or death.

CONSENT FOR MEDICAL TREATMENT/HOSPITALIZATION

I/We authorize Akron Children’s Hospital staff to provide routine healthcare and to administer the following medications (in original container) to _____ :
(Camper’s Name)

The following non-prescription medications are commonly stocked at camp and are used on an as needed basis to manage illness and injury. Please cross out the following items the camper should NOT be given:

Acetaminophen (Tylenol), Adhesive Bandages/Tape, Albuterol Sulfate, Aloe Vera Gel, Anesthetic throat spray, Bacitracin, Benadryl, Calamine Lotion, cough drops, D 50, EpiPen, Guaifenesin syrup, H2O2, Ibuprofen (Advil, Motrin), Loperamide, antidiarrheal, Mylanta, Neosporin, Pepcid, Pseudoephedrine, sunscreen, swimmer’s ear treatment, Tums.

In the event of injury or illness, I authorize the camp staff to administer treatments that are deemed necessary and to seek out appropriate emergency care including admission to a hospital if necessary.

Parent’s or Legal Guardian’s Signature Date / Witness Signature (required) Date



Diabetes Camp 2024 Behavior Agreement

For all campers, staff, and counselors to have a fun and exciting camping experience, there are some basic rules that all campers must follow. By signing this form, you agree to the following:

1. I will treat all campers, staff, counselors, and volunteers with respect.
2. I will follow directions given to me by staff, counselors, or volunteers.
3. I will be cooperative in the management of my diabetes, including but not limited to blood glucose testing, insulin injections or pump therapy, dietary management, and exercise.
4. I will learn as much as I can about taking care of my diabetes.
5. I will remain in designated areas with my cabin group, unless instructed by staff or counselors to go to another location.
6. I will let staff or counselors know when I need help with a problem.
7. I will not bring cell phones, electronic games, money, food, MP3 players, iPod, knives, or guns to camp. Camp is meant to be a recreational electronic free experience
8. I understand that I will not be able to call home during the time I am at camp.
9. I understand that physical violence, inappropriate or obscene language or sexual behavior is prohibited at camp and may result in my dismissal from camp.
10. I understand that illegal drugs, alcohol, and cigarettes are prohibited at camp and possession or use of these drugs will result in my immediate dismissal from camp.

Camper: I have discussed this agreement with my parent or legal guardian and I am willing to follow the above listed rules. I understand that if I don't follow these rules I could be sent home from camp.

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 behavior agreement of Akron Children's Hospital Diabetes Camp.

Camper's Signature

Date

Parent's Signature

Date