Akron Children's

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 16-20, 2025. It is hard to believe this is our 16th year of camp. Ages for eligible campers this year will be 9-14. Eligible patients must be 9 years old by June 16, 2025. 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

Camp application

1. Diabetes history
2. Health history
3. Food plan
4. Campership application (if applicable)
5. Activity and Medical Release Form
6. 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 4/25/25.**

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 16 in the afternoon and pick up will be Friday June 20 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 16, 2025,** to secure your child's spot at camp. A sports physical for the 2024-2025 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

2025 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?			☐ Yes ☐ No
T-Shirt Size (check one) Child ☐ S ☐ M ☐ L Adult ☐ S ☐ M ☐ L ☐ XL ☐ 2XL			Cabin Mate Request: _____ (We make every effort to accommodate special requests but cannot guarantee they will be honored)

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: 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
☐ resiba ☐ Lantus ☐ Levemir ☐ Basaglar ☐ Other: _____

Camp Experience/History:

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

Has your child ever been to another diabetes camp? ☐ 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: _____
_____

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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.

☐ Asthma _____
☐ ADD/ADHD _____
☐ Anxiety _____
☐ Depression _____
☐ Bedwetting _____
☐ Constipation _____
☐ DKA _____
☐ Heart Disease _____
☐ Severe Low Blood Sugar _____
☐ Eating Disorder _____
☐ Learning or Dev Disorder _____
☐ Problems Sleeping _____
☐ Seizures _____
☐ Other _____

Allergies
☐ Ivy Poisoning, Etc.
☐ Hay Fever
☐ Insect Stings
☐ Latex
(Such as examination gloves)

Drug and Other Allergies
_____
_____
_____
_____

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.) 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.

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

Medication	Dosage	Time	Reason for taking medication

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Diabetes Assessment Questions

Questions	Points Possible
How would you rate your child's independence in managing their diabetes? (good, fair, poor)	Good: 3 Fair: 2 Poor: 1
How would you rate your child's understanding of type 1 diabetes and how it effects their body? (good, fair, poor)	Good: 3 Fair: 2 Poor: 1
Overall, rate how you feel your child is/has been coping with their diagnosis? (good, fair, poor)	Good: 3 Fair: 2 Poor: 1

Nutrition Assessment

Does your child have celiac disease? ☐ Yes ☐ No

Does your child have any special dietary needs?

Food Allergies? _____

Food Intolerances? _____

Camp Fee Assistance Application 2025

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 2025

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: NOTE: Cross off medications after packet is printed.

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 2025 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

Save to computer

Print packet for signatures