



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 15-19, 2026. It is hard to believe this is our 17th year of camp. Ages for eligible campers this year will be 9-14. Eligible patients must be 9 years old by June 15, 2026. 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)

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 4/24/26.**

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 **\$50** 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 15th in the afternoon and pick up will be Friday June 19th 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 15, 2026**, to secure your child's spot at camp. A sports physical for the 2025-2026 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. Upon acceptance, additional forms will be sent for completion. 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,

Lisa M. Davis MSN, APRN, CPNP, Camp Medical Directors
Maggie Monroe BSN, RN Camp Director
Danielle Dimengo, MS, RD/LD, CDCES & Brooke Whaley, RD/LD, Nutrition Directors
Amanda Grewell, LSW



2026 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) Child S M L Adult S M L XL 2XL				Cabin Mate Request: <hr/> (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

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 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

Drug and Other Allergies

- | | |
|--|-------|
| <input type="checkbox"/> Ivy Poisoning, Etc. | _____ |
| <input type="checkbox"/> Hay Fever | _____ |
| <input type="checkbox"/> Insect Stings | _____ |
| <input type="checkbox"/> Latex | _____ |

(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. 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

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

Mental Health Assessment

Has your Camper:

1. Ever been diagnosed with ADHD, ADD, or Autism?
2. Ever been treated for emotional or behavioral concerns such as Depression or Anxiety?
3. During the past 12 months, seen a counselor, psychologist, psychiatrist, or other professional to address mental/emotional health concerns?
4. Had a significant life event that may affect the camper's mood while at camp? (e.g., death of a loved one, family change, foster care, new sibling, survived a disaster, etc.)
5. Been asked to leave an overnight camp early due to behavior?

Please explain "Yes" answers in the space below.

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 2026

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: _____