Akron Children's Hospital
Turner Syndrome Overnight Camp
Registration Application – Summer 2026

Camp Information

Location: Camp Asbury, Hiram, Ohio

Dates: July 19–22, 2026

Eligibility: Girls ages 9–17 years with Turner Syndrome who are followed by our clinic

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Camper Information

Camper Name: _____

Date of Birth: _____

Grade (Next School Year): _____

Parent / Guardian Information

Parent/Guardian Name: _____

Phone Number: _____

Parent/Guardian Name: _____

Phone Number: _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone: _____

Secondary Phone: _____

Email Address: _____

Preferred Method of Communication:

☐ Mail ☐ Email

Emergency Contact Information

If parent/guardian cannot be reached:

Name: _____

Phone Number: _____

Primary Care Provider

Pediatrician Name: _____

Phone Number: _____

Insurance Information

(Please include copies of front and back of insurance cards)

Insurance Company: _____

Policy Holder Name: _____

Policy/ID Number: _____

Group Number: _____

Camp Experience / History

Has your child attended camp before? ☐ Yes ☐ No

If yes:

Where: _____

How Long: _____

Your child makes friends with:

☐ Children her own age ☐ Younger children ☐ Older children

Medical Information

Please list any **medical, physical, social, or emotional concerns** (other than Turner Syndrome):

Does your child have difficulty falling asleep?

☐ Yes ☐ No

If yes, what strategies are helpful?

Medical History

Please **check and provide approximate date**:

☐ Asthma _____

☐ ADD / ADHD _____

☐ Anxiety _____

☐ Depression _____

☐ Bedwetting _____

☐ Constipation _____

☐ Heart Disease _____

☐ Eating Disorder _____

☐ Learning/Developmental Disorder _____

☐ Problems Sleeping _____

☐ Seizures _____

☐ Other _____

Allergies

☐ Poison Ivy / Environmental _____

☐ Hay Fever _____

☐ Insect Stings _____

☐ Latex _____

Drug/Food/Other Allergies:

Symptoms of allergic reactions:

Medications

(Medications must be sent in original containers. Please do not send vitamins or supplements.)

Medication	Dosage	Time	Reason

Nutrition Assessment

Does your child have celiac disease? ☐ Yes ☐ No

Does your child have special dietary needs?

Food allergies:

Food intolerances:

Activity Permission & Medical Consent

The staff of Akron Children's Hospital Turner Syndrome Camp has planned a full and active schedule for your child's session.

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 Turner Syndrome 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 understand participation includes inherent risks and I release Akron Children's Hospital and staff from liability associated with camp participation.

Parent/Guardian Signature: _____

Date: _____

Medical Treatment Authorization

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.

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, Aloe Vera Gel, Anesthetic throat spray, Bacitracin, Benadryl, Calamine Lotion, cough drops, EpiPen, Guaifenesin syrup, H2O2, Ibuprofen (Advil, Motrin), Loperamide, antidiarrheal, Mylanta, Neosporin, 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/Guardian Signature: _____

Date: _____

Witness Signature: _____

Date: _____

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:

I will treat all campers, staff, counselors, and volunteers with respect.

I will follow directions given to me by staff, counselors, or volunteers.

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.

I will learn as much as I can about taking care of my diabetes.

I will remain in designated areas with my cabin group, unless instructed by staff or counselors to go to another location.

I will let staff or counselors know when I need help with a problem.

I will not bring cell phones, electronic games, money, food, knives, or guns to camp. Camp is meant to be a recreational electronic free experience

I understand that I will not be able to call home during the time I am at camp.

I understand that physical violence, inappropriate or obscene language or sexual behavior is prohibited at camp and may result in my dismissal from camp.

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 parents or legal guardian, and I am willing to follow the above-mentioned rules. I understand that if I don't follow these rules I could be sent home from camp.

Camper Signature: _____

Date: _____

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 Turner Syndrome Camp.

Parent/Guardian Signature: _____

Date: _____

Additional Information

Help us to understand your child so that she will have a happy, safe, confidence-building camp experience. Please include difficulties with **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*** overnight experience for your child and her camp peers. (Please attach another sheet if needed.)

Registration Requirements

Completed packet must include:

- Camp Application
- Health History Form
- Food Plan Form
- Activity & Medical Release Form
- Behavior Agreement
- Campership Application *(if applicable)*

Note: Applications are reviewed only when all forms are received.

Enrollment & Deadline

- Limited to **20 campers**
- Placement based on **completed application date**
- Waiting list once full

Deadline: June 10, 2026

Camp Fee

Total cost: **$150 per camper**

- Due upon acceptance

- Do not submit payment with application

Camperships (Financial Assistance)

- Full and partial assistance available
- Minimum family contribution: **$30**
- Complete campership application if requesting assistance

Transportation

Drop-Off: Sunday, July 19, 2026 at 2:00 PM

Pick-Up: Wednesday, July 22, 2026 at 10:00 AM

Transportation is the responsibility of the parent/guardian.

Return Completed Packet To:

Akron Children's Hospital

Attn: Turner Syndrome Camp – Center for Diabetes and Endocrinology

215 West Bowery Street, Suite 6400

Akron, Ohio 44308