Welcome to Hot Shot Camp 2017!

Whether this is your first camp year or if you are a seasoned camper, DYS invites you to camp! At camp your child will learn practical strategies for managing his/her diabetes, but the primary reason kids love camp is because they have fun experiencing it.

Along with education from trained medical staff, your child will experience the fun of traditional summer camp in a wide variety of activities. A team of registered nurses, certified diabetes educators, and a registered dietician are on site, 24 hours a day. Your child will meet trained counselor and other campers who face similar challenges every day. Have peace of mind that Hot Shot Camps will be a safe, fun, and healthy environment for your child to make lasting memories.

Which camp will you attend?

- ☐ **Big Shots Resident Camp** (June 17 – 22, 2017), Recreation Unlimited, Ashley, OH – **entering grade 7-10**
- ☐ **Middle Shots Resident Camp** (June 23 – 25, 2017), Recreation Unlimited, Ashley, OH – **entering grade 4-6**
- ☐ **Little Shots Day Camp** (July 17-21, 2017), Olander Park, Sylvania, OH – **entering grade K-3**
- ☐ **Mini Shots Camp** (July 16, 2017), Olander Park, Sylvania, OH – **children up to Kindergarten**

Camp Fees

In order to give as many children as possible the opportunity to experience Hot Shot Camps, the registration fees cover only a fraction of the cost to send a child to camp. In order to further aid families with the registration fees**, scholarships are available**. **Please submit an additional application for a scholarship**. You can also solicit local businesses to sponsor your child at camp. Information on the sponsorship process is available online at www.dys4kids.org/camp.

Big Shots Resident Camp (~~$2100~~) your price $499

Middle Shots Resident Camp (~~$1300~~) your price $299

Little Shots Day Camp (~~$700~~) your price $199

Mini Shots Camp ($~~100~~) your price $25

Please complete this packet, and send to DYS along with the $25 registration deposit to hold your spot for this year. *Please note: Your $25 registration fee is included in the prices above.*

IMPORATANT DATES

Middle & Big Shot Camps	Item	Little Shot Camp
Wednesday April 5, 2017 3:00-7:00pm	If you need assistance filling out forms or have specific questions regarding camp please join us at the DYS office for a Hot Shot Camps Information Party	Wednesday April 5, 2017 3:00-7:00pm
Friday May 12, 2017	Camp registration packet due including: A.) camper photo B.) copy of medical insurance and prescription insurance cards (note: Recreation Unlimited consent is NOT needed for Little Shot campers)	Friday May 12, 2017
Friday May 26, 2017	(Optional) Scholarship Application and/or Sponsorship due including: A.) copies of documents for income/assistance verification	Friday May 26, 2017
Friday June 2, 2017	Notification of camp scholarship awards	Friday June 2, 2017
Friday June 9, 2017	Camp fees due in full	Friday June 30, 2017
1st day of camp: Saturday June 17, 2017 – Big Shot Campers Friday June 23, 2017 – Middle Shot Campers	Blood Sugar Log due	1st day of camp: Monday July 17, 2017

Please send forms to:
Diabetes Youth Services
2100 Central Ave Suite 110
Toledo, OH 43606
Fax: (419) 291-1235
Natalie@DYS4Kids.org

Camper name:_____ Year:_____

CAMPER DEMOGRAPHICS

Birth date: ____ /____ /____

Street address:_____

City: _____ State: _____ County: _____ Zip: _____

Child is (choose one): ☐ Male ☐ Female

Race / Ethnicity (choose one): ☐ White ☐ Black or African American ☐ Asian

☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander

☐ Two or more

Is your child (choose one)? ☐ Hispanic or Latino ☐ NOT Hispanic or Latino

School Name: _____ School District: _____

Grade level **next school year**: _____

T-shirt size (choose one youth OR adult size): Youth sizes: ☐ S ☐ M ☐ L ☐ XL

Adult sizes: ☐ S ☐ M ☐ L ☐ XL

Has your child ever been to a DYS camp before? ☐ Yes ☐ No

If Yes, year(s) attended: _____

Camper is attending camp with (optional):_____

Child has type 1 diabetes (choose one): ☐ Yes ☐ No

FAMILY CONTACT INFORMATION

Mother or legal guardian name: _____

Address (if different from child): _____

Home phone: (____) _____-_____ Cell phone: (____) _____-_____

Work phone: (____) _____-_____ Email: _____

Father or legal guardian name: _____

Address (if different from child): _____

Home phone: (____) _____-_____ Cell phone: (____) _____-_____

Work phone: (____) _____-_____ Email:_____

Camper name:_____ Year:_____

GENERAL HEALTH HISTORY

Please list the name and contact number for your child's doctors below:

Diabetes Care Provider:_____Phone:_____

Pediatrician:_____Phone:_____

Dentist:_____Phone:_____

Check all health conditions that apply to your camper and explain in space provided:

- ❑ Hay fever:_____
- ❑ Poison ivy:_____
- ❑ Insect stings:_____ _____
- ❑ Skin problems:_____
- ❑ Asthma:_____
- ❑ Ear infections:_____
- ❑ Headaches:_____
- ❑ Seizures:_____
- ❑ ADHD:_____
- ❑ Autism:_____
- ❑ Behavioral:_____
- ❑ Bed wetting:_____
- ❑ Insomnia/sleep disturbances:_____
- ❑ Diarrhea or constipation:_____
- ❑ Recent injury:_____
- ❑ Surgical history:_____
- ❑ Other (specify): _____
- ❑ Check if it applies: ☐ Glasses ☐ Contacts

Has the camper: Had a significant life event that continues to affect the camper's life (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)? ☐ Yes ☐ No

If yes, please explain:_____

Camper name:_____ Year:_____

_____

_____

_____

NUTRITION INFORMATION

Does your child have Celiac Disease? ☐ Yes ☐ No

Does your child have any food allergies? ☐ Yes ☐ No

If "Yes" please list:_____

_____

Does your child have a eating disorder? ☐ Yes ☐ No

If yes, please explain:_____

_____

Is your child a picky eater? ☐ Yes ☐ No
If "Yes" please list foods your child likes:_____

Dislikes:_____

Do you plan to send special food to camp for your child? ☐ Yes ☐ No

Does your child eat additional food for increased or vigorous activity? ☐ Yes ☐ No

Please describe additional foods and amount eaten for each hour of increased activity:

_____

Please provide ranges on the number of carbohydrates (in grams) that your camper is allowed per meal:

Check here if your child does NOT have a carbohydrate limit at meals and will just be given insulin to cover the food chosen to eat: ☐

Breakfast	Snack	Lunch	Snack	Dinner	Bedtime

Camper name:_____ Year:_____

MEDICATIONS

Other than insulin, are there any medications your camper takes on a regular basis?

Medication	Dose	Time(s)	Give at Camp?

Medication allergies? ☐ Yes ☐ No

If "Yes" please list:_____

_____

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. CROSS OUT any medications the camper should NOT be given:

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol

DIABETES SPECIFIC HEALTH HISTORY

Date of diagnosis: ____/____/_____ Age at Dx: _____

Last A1C: _____ Date of last A1C: ____/____/_____

List any hospitalizations due to diabetes (dates and explanations). History of diabetic ketoacidosis (DKA), severe low(s), or other diabetes-related complications:_____

_____

_____

Camper name:_____ Year:_____

PHYSICAL EXAMINATION

A physician must assess your child and sign this form.

This does NOT have to be the child's endocrinologist.

Height:_____ Weight:_____ T:_____ P:_____ R:_____ BP:_____/_____

EYES:_____

ENT:_____

NEURO:_____

CARDIAC:_____

RESP:_____

GI:_____

GU:_____

MS:_____

SKIN:_____

List any specific activities to be encouraged or restricted:_____

_____

List any physical or emotional issues that might create a problem for this child at camp:

_____

_____

List any additional health information that might be relevant for camp staff:_____

_____

☐ I have examined the person herein described and have reviewed his/her health history. It is my opinion that this person is physically able to engage in all camp activities except as noted above.

_____

Printed Name of Health Care Professional

_____

Signature of Health Care Professional Date

_____

Address Phone Number

Camper name:_____ Year:_____

INSULIN INJECTION FORM

Please use this form if your camper is on insulin injections per syringe or pen. If your camper uses the pump, please fill out the corresponding insulin pump form only. Please do not write in greyed out areas as that is for staff use. ☐ **Pen** ☐ **Syringe**

Quick Acting Name _____

Long Acting Name _____ **A.M. Dose**_____ **P.M. Dose**_____

Dose Changes at Camp [To be Completed by Staff Only] _____ _____

Amount of Insulin Given in Units for Every Gram of Carbohydrate

MEAL	Grams of carbohydrate	# units insulin given	Changes Note Here [Staff Only]
Breakfast			
AM Snack			
Lunch			
PM Snack			
Dinner			
Bedtime Snack			

Scale for Blood Sugars

BS Range	# units insulin given	Changes Note Here [Staff Only]

Scale for Ketones

Ketone Level	# units insulin given	Changes Note Here [Staff Only]
Trace		
Small		
Moderate		
Large		

Adjustments for Activity

Camper name:_____ Year:_____

INSULIN PUMP FORM

Pump Brand _____ Color _____ Serial # _____

Type of insulin: ☐ Humalog ☐ Novolog ☐ Apidra

How often is cartridge changed? _____

How often is infusion set changed? _____

Ketone Coverage:

____ units insulin / trace ____ units insulin / moderate

____ units insulin / small ____ units insulin / large

BOLUS DOSES
Number of Carbs Covered by one unit of insulin

Meal	Time	Grams CHO	Camp Changes
Breakfast			
Mid-Morning Snack			
Lunch			
Afternoon Snack			
Supper			
Evening Snack			
Target Blood Sugar			

BASAL RATES

Time	Rate	Camp Changes

Correction / Sensitivity Factor

Insulin On Board # of Hours

_____

Camper name:_____ Year:_____

DIABETES SELF-CARE CHECKLIST

Please indicate if your camper has developed the following skills:

Skill	Yes	No
Testing own blood sugar with a meter		
Performing control tests on meter		
Storing and handling insulin and supplies		
Drawing up insulin in a syringe		
Using an insulin pen		
Giving self an injection with a syringe or insulin pen		
Rotating injection sites		
Counting carbohydrates		
Calculating carbohydrate to insulin ratios		
Adjusting insulin for physical activity		
Recognizing symptoms of high and low blood sugars		
Treating low blood sugars		
Covering high blood sugars		
Using an insulin pump		
Using a continuous glucose monitoring system (CGMS)		
Inserting pump sites		
Inserting CGMS sites		
Understanding basic pump operation		
Understanding basic CGMS operation		
Understanding advanced pump operation and trouble shooting		
Understanding advanced CGMS operation and trouble shooting		
Ketone testing		
Foot care		
Sick day management		

List 3 goals your camper has for this camp session:

1. (Medical)_____
2. (Nutritional)_____
3. (Social)_____

Camper name:_____ Year:_____

CONSENTS

Consent	Parent /guardian initials
Medical agent: On behalf of my heirs, executors, administrators and assigns, I, for myself and/or on behalf of my child, hereby waive, discharge and release any and all rights and claims for damages which my child and/or I may have against DYS or any other facility and their management, as well as any other person connected with DYS, their heirs, executors, administrators and assigns, for any and all injuries which I/my child may suffer while taking part in DYS camps or as a result thereof. I appoint DYS Camp Director, or his/her designee, to be my agent for consenting to emergency medical care and treatment of my child in my absence. If I (or other emergency contact) am unavailable or cannot be located, our agent may consent to any medical examination, x-ray or other diagnostic procedure, anesthetic, medical or surgical procedure or treatment, or hospital care of my child that is recommended by a physician. I authorize any physician who has treated my child or any hospital in which our child has been admitted to surrender physical custody of my child to our agent. This authorization makes our agent a "person who has legal authority to consent to medical treatment or hospital care on behalf of" our child under Ohio Revised Code Section 2317.54 (C). I am giving this authorization before any specific diagnosis, treatment, or hospital care of our child is required. I intend this authorization to help make available to our child medical care and treatment that may be required in the future. I authorize Diabetes Youth Services to release or receive all medical records for the above named camper, including but not limited to those records pertaining to substance abuse and emotional or mental health. My authorization shall remain effective for the entire camp session, unless the physician or hospital acting under this authorization has been notified in writing that my authorization has been revoked.	_____
Activities: I permit my child to participate in all phases of the activities, both on and off camp property. I understand that my child may be participating in high-risk activities, but will be under DYS Camp Staff supervision at all times.	_____
Insulin: I consent to having my child follow DYS method of diabetes treatment as outlined in the "DYS Hot Shot Camper Manual" and to use approved supplies while at camp. I further agree that at DYS Hot Shots Camps, insulin must be administered--whether by injection or pump---under the direct supervision of a qualified medical staff member any time insulin is given. DYS has my permission to adjust insulin dosages while my child is at camp.	_____

Camper name:_____ Year:_____

Diabetes technology: DYS is not responsible for any damage to and will not replace your child's insulin pump or continuous glucose monitoring system (GCMS). If damage occurs to any of this equipment while participating in camp, your family will bear the cost of replacement. We strongly encourage you to insure your child's diabetes technology by securing a "loss policy" as an *addition* to your homeowner's or renters insurance. Homeowner's or renter's insurance covers this equipment only in very extreme circumstances. A specific loss policy will cover equipment replacement if it is lost or damaged, at home or at camp. The costs of these policies vary; please contact your insurance agent for more information. If you have insurance for your child's insulin pump or continuous glucose monitoring system, please copy the declarations page and attach to this document.	_____
CGMS: 1. CGMS will not be used for insulin dosing. 2. Campers will still be required to check blood glucose via glucose meter per camp protocol and when instructed by the medical staff. 3. At camp, our glucose target is often higher than home glucose targets (generally <180 mg/dL). Alerts/Alarms from CGMS will be verified with a blood glucose via glucose meter and treated according to established camp protocols. To prevent frequent alarms, we strongly recommend changing alarm parameters: o Low Alert <80 mg/dL o High Alert <300 mg/dL o Disable high prediction alert and rise rate 4. If the CGMS sensor becomes dislodged, errors, or fails, a replacement sensor will be put back on the camper at the next meal (activities will not be interrupted for CGMS failure). Campers must bring their own CGMS supplies. 5. The medical staff has permission to download and review CGMS data for medical purposes. 6. If the CGMS unit becomes a distraction, the medical staff reserves the right to turn off the CGMS unit. 7. No remote monitoring of CGMS units will be allowed (campers are not allowed to have non-medical electronic devices). Camp policy prohibits the use of cell phones at camp. Violations of this will result in removal of the CGMS and transmitting device (cell phone).	_____

Camper name:_____ Year:_____

Contact information: I give my permission for DYS to add/update my family's information in the DYS general mailing database. I also permit my child's name and contact information to be listed in a DYS Camp Directory.	_____
Pictures: I hereby give DYS, their legal representatives or assigns, and those acting under their permission and upon their authority, or those for whom DYS is acting, permission to use my/my child's picture, and if desired, my/my child's name in advertising and in all forms of publicity, without limit as to time. I, for myself and/or on behalf of my child, further release DYS from my liability for what my child and/or I might deem misrepresentation of me by virtue of alterations, optical illusions or faulty mechanical reproductions in such advertising and/or publicity.	_____
Early departure: If the camper must leave camp before the specified pick up time, please notify DYS staff in writing as soon as possible. If for some reason I am not able to take my child home from camp, I give my permission for my child to be taken home by: Name:_____ Relationship:_____ Phone number:_____	_____

By signing below, I confirm that I have reviewed the DYC Hot Shot Camper Manual with my child and all forms are complete and accurate to the best of my knowledge.

_____

Parent/Guardian Signature/initials Date

_____

Camper Signature Date

Emergency Medical Authorization And Liability Release For Lease Group Participants

Group Name

Participants Name

Age

Purpose: To enable independent adult participants or the parents/legal guardians of participants to authorize the provision of emergency treatment for participants who become ill or injured while under the supervision of Recreation Unlimited Farm and Fun instructors during programs, events and activities at Recreation Unlimited Farm and Fun.

A. Complete Only If Above-Named Participant is Under Age 18 or Not His/Her Own Legal Guardian

In the event of a medical emergency involving the above-named participant, if reasonable attempts to contact me at one of these phone numbers: _____ or _____ or at _____ (the other parent or legal guardian) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) at _____ (phone) or Dr. _____ (preferred dentist) at _____ (phone) or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the above-named participant to (preferred hospital) _____ or any other hospital reasonably accessible.

B. Complete Only If Above-Named Participant is Over Age 18 and is His/Her Own Guardian

I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) at _____ (phone) or Dr. _____ (preferred dentist) at _____ (phone) or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer to (preferred hospital) _____ or any other hospital reasonably accessible.

I hereby forever release, waive, discharge, and covenant not to sue Recreation Unlimited Farm and Fun and/or the sponsoring agency, its associates, volunteers, agents, successors, assigns, trustees, and/or members, its affiliated clubs, their representative administrators, directors, coaches, other participants, sponsoring agencies, individual sponsors, advertisers, heirs, and if applicable, owners and lessors of premises used to conduct the event, all of whom are hereinafter referred to as “the Release Parties,” from demands, losses, claims or damages arising from injury to the above-named participant or his/her property caused or allegedly caused, in whole or in part, by the negligence of the Release Parties or otherwise, that occurs during programs, events or activities, in transit to or from Recreation Unlimited Farm and Fun, or during any activity approved by the Released Parties.

I hereby covenant and agree to indemnify and save harmless the Release Parties from any and all damages, expenses, fees, costs, claims, losses arising out of any loss or injury sustained by the above-named participant as a result, in whole or in part, of the Release Parties furnishing medical care to above-named participant or the Release Parties arranging for the hospitalization and medical care of the above-named participant.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Facts concerning the participant's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted (attach additional sheets, if necessary):_____

All program activities at Recreation Unlimited are activities by choice. It is the responsibility of the participant or Lease Group representative for the participant to choose not to participate in an activity that may adversely affect physical or mental health.

I/WE HAVE READ THE ABOVE AUTHORIZATION AND UNDERSTAND THAT I/WE HAVE GIVEN UP SUBSTANTIAL RIGHTS AND HAVE ACCEPTED/ASSUMED SUBSTANTIAL RISK AND LIABILITY.

I certify, warrant and represent to possess the cognitive ability to read and comprehend all the statements made in this form.

I certify, represent, and warrant that I am either the above-named participant at or beyond the age of majority, with the legal capacity and cognitive ability to sign this form, or the parent/legal guardian of the above-named participant with the legal authority, cognitive ability and legal capacity to sign this form on behalf of the above-named participant.

First Parent/Legal Guardian or Participant Age 18 or Older and His/Her Legal Guardian

Date

Print Name

*Second Parent/Legal Guardian

Date

Print Name

*Note: If second parent signature is not possible, then the first parent/guardian certifies that the second parent/guardian's signature is not required or the second parent/guardian has authorized the above-named participant to pursue this activity and agrees to all statements listed above.

THE FOLLOWING INFORMATION IS REQUIRED: INSURANCE COVERAGE for accidents or illness while participating in programs as a lease group participant at the facility of Recreation Unlimited Farm and Fun is the responsibility of the participant and/or family/legal guardian. Please list major medical accidental/health insurance coverage and/or Medicare/Medicaid information.
INSURANCE CARRIER:
POLICY/GROUP NUMBER:
MEDICARE NUMBER:
MEDICAID NUMBER:

Camper name:_____ Year:_____

BLOOD SUGAR LOG

Please fill in this chart with blood sugars, carbs consumed, and insulin doses from the **week prior** to your child's session at camp.

Day	Breakfast			Lunch			Dinner			Bed			2 am BG (Optional)	Comments
	BG	Carb	Insulin	BG	Carb	Insulin	BG	Carb	Insulin	BG	Carb	Insulin		
Mon														
Tues														
Wed														
Thurs														
Fri														
Sat														
Sun														

Date of last pump site change (if applicable): _____/_____/_____

Date of last CGM site change (if applicable): _____/_____/_____

DO NOT MAIL THIS FORM. BRING IT WITH YOU TO YOUR FIRST DAY OF CAMP.