Office Only: Date Received: _____Payment Received: _____
Group Name: _____Counselor: _____Room: _____

CAPE FEAR VALLEY KIDS with DIABETES

Diabetes Camp Application
Camp Rockfish
July 11,12,13, & 14 2019

Camp FEE
☐ **Day Camper ($70) (Ages 2-5)**
☐ **Overnight Camper ($160) (Ages 6-18)**

You must complete the following:

1. **Camp Application (Online Registration: Sweetkidswithdiabetes.com/diabetescamp)**
2. **Copy of your child's immunization record must be attached to the Physical Exam Report**
3. **Early registration January 2 - Friday June 7th, 2019**
4. **Late Registration June 10th – Friday June 28th, 2019 (Overnight Camper $180) (Day Camper $85)**

We will not accept applications turned in after Friday June 28th. *NO EXCEPTIONS WILL BE MADE*!

CAMP LOCATION: Camp Rockfish: 226 Camp Rockfish Rd, Parkton NC 28371.
DROP OFF: 3 pm on Thursday July 11th
PICK UP: 12 pm on Sunday July 14th **(There will be a charge of $1.00 for every minute late)**

We will check for head lice at registration and children diagnosed with live head lice will not be able to stay at camp Friday night. Parents or Guardians should treat their child immediately and return him/her to camp the next day.

Date of Birth: _____

Camper's Name (last, first): _____

Address: _____

City: _____ State: _____ Zip Code: _____

1. Health History to be completed by Parent/Guardian. Attach additional pages if necessary.

	Yes	No			Yes	No
ADHD				**Hearing Disorder**		
Allergies				**Hypertension**		
Asthma				**Neuromuscular Disorder**		
Autism				**Orthopedic Condition**		
Cardiac				**Respiratory Illness**		
Celiac				**Seizure Disorder**		
Diabetes				**Thyroid Disorder**		
Skin Disorder				**Vision Disorder**		
Gastrointestinal						

2. Does the child have any conditions, medical or otherwise, other than diabetes? Please explain below:

_____
_____
_____

3. Please specify medications, for ***other*** than diabetes:

Medication Name	Time Given	Dose	Reason for Taking

4. List any Allergies:

_____

_____

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

_____

_____

6. Is the child a new camper (circle one)? Yes No

7. Child's Primary Provider: _____ 8. Diabetes Doctor_____

9. Social Worker &/or Psychologist, or other relevant provider: _____

10. We **must** have phone numbers where parents/guardians can be reached for the entire camp session. We must also have the phone number of a relative/friend who can be reached if parents/guardians are unavailable.

a. Parent or Guardian Name: _____
Contact Number: _____
Contact Email: _____

b. Friend or Relative Name: _____
Contact Number: _____
Contact Email: _____

12. Who will pick up your child at the end of camp & what is their relationship to the camper?
_____

13. Insurance Information:
Primary Insurance Company: _____ Phone: _____
Policy #:_____ Group #: _____
Policy Holder's Information:
Name & Relationship to Camper: _____
Date of Birth: _____ Social Security #: _____
Employer: _____
Copay: _____

Secondary Insurance Company: _____ Phone: _____
Policy #: _____ Group #: _____
Policy Holder's Information:
Name & Relationship to Camper: _____
Date of Birth: _____ Social Security #: _____
Employer: _____
Copay: _____

To be completed by Provider:

Child's Name & Date of Birth: _____

Report of Physical Examination (circle one): Yes No

Height: _____ Weight: _____ BMI: _____ Pulse: _____

Blood Pressure: _____

System	Normal	Abnormal	Did Not Examine	Comments
Hair/Scalp				
Skin				
Eyes/Vision				
Ears/Hearing				
Nose & Throat				
Teeth & Gingiva				
Lymph Glands				
Heart – Murmur, etc				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine				

Diabetes Medications:

Long Acting Insulin Type: _____ Given (circle one): am pm Dose: _____

Rapid Acting Insulin Type: _____ Carbohydrate Ratio: 1 unit per _____ grams

or Fixed Doses: _____

Correction Factor: 1 unit per _____ above _____ Target Blood Glucose: _____

or Sliding Scale:

_____

Insulin Pump: Animas Medtronic OmniPod T-Slim Basal Rates:

Time	Rate

Metformin Dose and Frequency: _____

Other Diabetes Medication Name, Dose, Frequency: _____

Date of Examination: _____ Signature of Examiner: _____

Print Name of Examiner: _____

Address: _____

Phone: _____ Fax: _____

****Please attach Immunization Record****

CAPE FEAR VALLEY HEALTH

Consent, Authorization, and Release Form

I, _____, hereby authorize Cumberland County Hospital System, Inc. d/b/a Cape Fear Valley Health System ("Cape Fear Valley") its employees, agents or authorized representatives to photograph and record me to use the photograph(s) and recordings of me and/or my likeness in Cape Fear Valley promotional material, multimedia (such as television, press or internet), film, video, and/or digital images.

I authorize Cape Fear Valley to use, reproduce, publish, transmit, distribute and display said photograph(s) and/or my likeness in any Cape Fear Valley publication, multimedia production, film, video, CD-ROM, DVD, display, illustration, advertisement, website, or other material for promotional purposes.

I authorize the use of these materials indefinitely without compensation to me. All negatives, positives, prints, digital reproductions and video and audio recordings shall be the property of Cape Fear Valley.

I also hereby agree to release, defend and hold harmless Cape Fear Valley, its employees, agents, officers, trustees or authorized representatives from any and all claims, damages, liability or causes of action that I may have of whatever nature, actions, and causes of liability, damages, costs, and loss of services. This release includes in any manner any damages resulting from the use of the photograph, recording, and/or my likeness, including but not limited to, any claims for defamation or invasion of privacy.

By signing below, I am indicating that I am of legal age, have read and fully understand this "Consent, Authorization, and Release Form," and I consent voluntarily.

Signature: _____ Date: _____Time: _____

Name (Please print): _____

Witness Signature: _____ Date: _____Time: _____

Witness Name (Please print): _____