Dear Parents and Campers,

With the New Year comes a new season of Camps at Camp Aldersgate. We are excited that our Spring Weekend Camps are filling up, and we look forward to what this summer has in store! Registration for the following camps is currently open:

Weekend Camps

****Returning summer campers, please note that you may now be able to attend Weekend Camps****

- Weekend residential camping experiences that utilize a strength-based approach to design programming and guide camper placement
- Occur each month throughout the school year (see our website for a calendar and more information)
- Camp Aldersgate has secured partial funding to aid families in covering the tuition. Fees are determined on a sliding scale based on family income.
- Serves campers with special needs, ages 6-18, who meet one of the following criteria:
    1. Eligible for a Camp Aldersgate Summer Camp
    2. Receives special education and "related services" in the school setting
    3. Requires the use of assistive devices and adaptations to complete Activities of Daily Living (ADLs)

Kota Camps

- Inclusive, week-long and weekend residential camping experiences for children with and without disabilities
- Camp Aldersgate has secured partial funding to aid families in covering the tuition. Fees are determined on a sliding scale based on family income.
- More information regarding the Kota Camps registration process, Financial Disclosure and tuition can be found online or by calling the office.
- The first round of placements for Spring and Summer Kota Camps will be completed March 15th, and priority will be given to those who have completed and returned applications by this date. The final deadline for Kota applications is April 16th.

Residential Summer Camps

- Week-long residential camping experiences for campers with specific medical diagnoses
- Offered in collaboration with local health agencies (contact information listed in application)
- Contact the health agency for details regarding camper tuition, fees, and camper scholarships

Summer Day Camp

- 6-week day camp designed for children with autism spectrum disorder, grades K-8th
- Contact A-Camp for information regarding tuition, fees, & scholarships

We strongly encourage you to complete registration as soon as possible to help ensure your child's participation. If you need additional copies of applications or have any questions, please just give us a call or visit our website, www.campaldersgate.net. **A complete application, including your Physician's Authorization, is necessary to secure placement in any of our programs.**

Sincerely,

The Camp Aldersgate Program Team

Ali Miller Berry | Katie Jenkins | Ian Shuttleworth | Nathan Nelson

2018 Summer – Camp Aldersgate and MedCamps Partnering Health Agencies

Muscular Dystrophy Camp: June 10 – 15

Age: 8 to 17
Contact: Kara Evans
Muscular Dystrophy Association
Phone: 501.227.7098
email: kevans@mdausa.org
Camp Physician: Richard Nix, M.D.

Applications available and returned through MDA

Spina Bifida Camp: June 17 – 22

Age: 6 to 16
Contact: Brad Caviness
Arkansas Spinal Cord Commission (ARSCC)
Phone: 501.296.1788 or 1.800.459.1517
email: brad.caviness@arkansas.gov
Camp Physician: Vikki Stefans, M.D.

Applications available and returned through ARSCC

Kota Camps: Session I June 24 – 29
Session II July 8 – 13

Inclusive camps for children with various disabilities and their non-disabled siblings and friends.
Age: 6 to 18
Contact: Camp Aldersgate
Phone: 501.225.1444
email: amiller@campaldersgate.net
Camp Physicians:
Session I – Jill Fussell, M.D.
Session II - Gene France, M.D.

**Download applications on website – First Selections Will be made on March 16th, Final Deadline is May 16th **

Diabetes Youth Camp: July 15 – 20

Age: 8 to 13
Contact: Lora Furstner
American Diabetes Association
Phone: 913.383.8210 x 6848
email: lfurstner@diabetes.org
Camp Physician: Jon Oden, M.D.

Download applications on website – Due May 16th

Arthritis Camp AcheAway: July 22 – 27

Age: 6 to 16
Contact: Emily Pearce
Arthritis Foundation
Phone: 501.708.2917
email: epearce@arthritis.org
Camp Physician: Jason Dare, M.D

Download applications on website – Due May 16th

Kidney Camp: July 22 - 27

Age: 6 to 18
Contact: Kirsten Sowell
Phone: 501.364.1406
email: sowellkl@archildrens.org
Camp Physician: Eileen Ellis, M.D.
Saritha Ranabothu, M.D.

Download applications on website – Due May 16th

Cardiac Camp: July 22 – 27

Age: 6 to 18
Contact: Angie Smith
Phone: 501.364.1479
email: smithangelaj@uams.edu
Camp Physician: Paul Seib, M.D.

Download applications on website – Due May 16th

Bleeding Disorders Camp: July 29 – August 3

Age: 6 to 16
Contact: Kara Burge
Arkansas Center for Bleeding Disorders
Phone: 501.364.1494
email: kburge@archildrens.org
Camp Physician: Kimo Stine, M.D.

Download applications on website – Due May 16th

Oncology Camp: July 29 – August 3

Age: 6 to 16
Contact: Tara DeJohn
Jennifer Taussig
Phone: 501.364.1494
email: dejohntv@archildrens.org
email: taussigjl@archildrens.org
Camp Physician: Kimo Stine, M.D.

Download applications on website – Due May 16th

A-Camp: June 11 – August 2

Inclusive Day Camp designed for children with ASD
6 Week Program; Monday – Thursday Weekly*
Contact: Camp Aldersgate
Phone: 501.225.1444
email: nnelson@campaldersgate.net
Partnering Agency: A-Camp
Contact: info@a-camp4kids.org
*no camping session July 2 – 5

Download applications on website – Due May 1th

MedCamps Diabetes Youth Camp
July 15 - 20, 2018

Attach Recent Photo Here

Type of Diabetes diagnosed_____ **Date of diagnosis:**_____

Physician's Printed Name:_____

Camper Application

Date of this application: _____/_____/_____

Please indicate the program and year your child last attended: New Camper._____ Summer Camps yr._____

T-shirt size: _____

CAMPER INFORMATION

Name:_____ Birth Date:_____/_____/_____
(Last, First, Middle)

Gender (F/M):_____ Where is your child's primary residence? (with Both parents, Mother, Father, Guardian)_____

Primary Medical Diagnosis/Condition (if not applicable write "none"):_____

List any Secondary Diagnoses/Conditions:_____

How did you hear about Camp Aldersgate's camping programs?_____

If possible, this applicant would like to be assigned with the following cabinmate(ages needs to be within 2 years):_____

PARENT/GUARDIAN INFORMATION

Primary Parent or Guardian Job Title:_____

Name:_____ Employer:_____

Telephone Numbers: Home_____ Work_____ Cell/Pager _____

Email:_____

Address:_____ City:_____

County:_____ State:_____ Zip:_____

Second Guardian Job Title:_____

Name:_____ Employer:_____

Telephone Numbers: Home_____ Work_____ Cell/Pager _____

Email:_____

Address:_____ City:_____

County:_____ State:_____ Zip:_____

EMERGENCY CONTACT INFORMATION

Who will be the primary contact while your child is at camp? *(circle)* ***Mother*** ***Father*** ***other***_____

Best phone number to call:_____/_____

If unable to reach parent/guardian, please notify: *(Two different individuals not living in the same household are* ***required.****)*

1) Full Name:_____ Relationship to camper:_____

Daytime telephone:_____ Evening telephone:_____

2) Full Name:_____ Relationship to camper:_____

Daytime telephone:_____/_____ Evening telephone:_____/_____

PARENT/GUARDIAN AUTHORIZATION

*The following authorization **MUST** be signed before applicant can be accepted as a camper.*

The health history I have provided in this application is correct and complete as far as I know. I agree to inform the camp of any significant health related issues that may arise following submission of this application and prior to my child's/ward's participation in the camp's programs and understand additional information and/or physician authorization may be requested. I give permission to Camp Aldersgate, Inc. to provide routine health care, administer prescribed medications, and seek emergency medical treatment including x-rays or routine tests for my child/ward :**(name of camper)**_____.
I give permission for my child/ward (named above) to participate in the programs at Camp Aldersgate, Inc., in all camp activities, including field trips away from camp, except as noted by the physician or parent/guardian. I hereby release Camp Aldersgate, Inc., its Board of Directors, employees, volunteers, collaborating agencies, physicians, agents, independent contractors, and any and all parties of interest from all claims, demands, grievances and causes of action of every kind whatsoever, including, but not limited to, all which may arise from or out of any injury incurred by my child/ward (named above) while in attendance at the camp. This includes any necessary transportation.

In the event I cannot be reached in an emergency, I give permission to the physician selected by Camp Aldersgate, Inc. to secure and administer any necessary treatment, including hospitalization for my child/ward (named above). I give permission to Camp Aldersgate, Inc. to arrange necessary related transportation for my child/ward (named above).

I give permission for Camp Aldersgate, Inc. staff to administer over-the-counter medications for my child/ward (named above) if the camp medical staff deems it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise.

I agree to the release of any records necessary for insurance purposes and give permission for Camp Aldersgate, Inc. personnel to receive information concerning my child/ward (named above) from various medical, therapeutic, and other professionals which may be necessary for participation in Camp Aldersgate, Inc. programs.

I grant full permission and authority to Camp Aldersgate, Inc., its collaborating agencies, and their representatives to photograph my child/ward (named above) and to use, publish, and release for publication such photos relating to the programs of the above named organizations. The name of my child/ward may be used in connection with the above, with the understanding that there is to be no exploitation of the family member and that any photographs so used should conform to standards of good taste.
This form may be photocopied for use outside of camp. My signature below indicates that I have read and agree with all the statements of the Parent Authorization.

Camp Aldersgate may not be able to accommodate all medical conditions and/or disabilities. Camp Aldersgate reserves the right to make the final decision regarding admittance and dismissal of participants to its programs. This policy is to insure that adequate provisions can be made for participants while they are in the care of the camp.

Camp Aldersgate serves those who do not: require personal caregivers other than camp staff or engage in aggressive and/or abusive behavior. Campers are recruited on a non-discriminatory basis, without regard to race, color, creed, sex, national origin, religious or political affiliation.

Signature of Parent/Guardian:_____ Date:_____

OPTIONAL INFORMATION

The following section is information used solely for gathering statistical information and obtaining grant funding. Omission of any or all questions will not affect the status of your application. This assists Camp Aldersgate in securing funding to lower program costs. Answer questions as they pertain to your child and his/her household.

Ethnic Origin: Black/African American Asian White American Indian Hispanic/Latino Other:_____

Religious Affiliation: _____ **Place of Worship (if applicable)**_____

Household Information: (circle one) two parent one parent

Number of Children, not including camper, living in household:_____

Household Annual Income: (circle one) less than $25,000 $25,001-$35,000 $35,001-$50,000
$50,001-$75,000 $75,001-$100,000 $100,001+

PERSONAL CARE AND ACTIVITY INFORMATION

The following specific applicant information is to be completed by parent/guardian for camp medical staff. A copy will be given to the applicant's counselors. Please attach any additional information necessary to assist the counselors and volunteers to care for your child.

Does the camper like to be called by any other name? _____ Age during camp:_____

Current grade in school:_____ Height:_____ Weight:_____ Gender: (M/F) _____

Please indicate (√) the level of assistance needed for the following daily activities

Personal Care Activity	needs no assistance	minimal assistance	total assistance	notes/needs
brushing teeth				
showering				
dressing				
hair brushing				
transfer (to and from wheelchair)				

Camp Activity	needs no assistance	minimal assistance	total assistance	should not participate	notes/needs
swimming					
SCUBA					
fishing					
canoeing/boating					
outdoor sports and games					
archery					
adventure challenge activities (ropes course)					
nature trails					
arts/crafts					

Please circle/write the appropriate information below (attach additional page if needed)

Ambulation: wheelchair: *manual* *electric* walker
crutches braces walks alone - no devices
wanders? yes no occasionally

Sleeping: no problems needs help turning over
needs help getting in or out of bed needs bed rails
wets bed wears diapers at night walks in sleep
usual sleep time: from_____p.m. to_____a.m.

Behavior: no problems use time out (minutes:_____)
problems triggered by:_____
positive reinforcers:_____
suggestions:_____

Toilet Management: no problems diapers training pants
catheterization every _____ hours self-catheterization
catheter size_____ brand_____ type_____
usually has bowel movement every_____ day(s)
needs help with:_____

What does the applicant take for pain/discomfort:
_____

Eating: no assistance needed at meals regular diet
G-Tube NG-Tube tube feedings every_____ hours
food must be: cut chopped mashed pureed
must be fed special utensils:_____
needs help with:_____
special diet:_____

Seizures: none has seizures date of last one_____
Type_____
usual duration_____ usual frequency_____
triggered by_____

Communication: no problems non-verbal sign language
limited abilities can communicate personal care needs
communication device (type_____)

Hearing: no problems oral deaf
hearing impaired wears aides

Vision: normal wears glasses limited blind

Heat Tolerance: good fair poor

Special Instructions and Daily Routines

Camp Aldersgate strives to make each camper's participation a safe, comfortable, and fun experience. It is important that we have as much information as possible regarding what your child is used to and comfortable with. Sometimes following routines or special ways of doing things helps a camper feel more at ease with a new environment. Please take a few moments and share with us your child's typical daily routine (especially consistent behavior problems, as well as personal care and mealtime procedures) and include any special instructions, techniques of motivating and rewarding your child, hobbies, likes/dislikes, etc. Everything that you provide will help us better care for your child.(example: My child will only settle down at night if I rock her. She will smile each morning if I hum a song to her.) Also include any goals you would like the applicant to achieve during their stay at camp.(examples: improve personal care skills, make new friends, learn to float in pool, etc.) Enclose extra pages if necessary.

Insurance Information

Camp Aldersgate provides medical insurance coverage which is **supplemental** to your existing health insurance. Our insurance covers all campers for accidents and illnesses that are camp related.

Name of carrier:_____ Policy or Group #:_____

Medicaid #:_____ Hospital preference in Little Rock (if any):_____

Name of Primary Care Physician:_____

Physician's office phone: (_____)_____ Physician's emergency phone: (_____)_____

Address: _____ City: _____ State: _____ Zip: _____

Immunization History

We are required to have a copy of each camper's immunization record on file.

New campers at Camp Aldersgate - a ***complete*** copy of his/her immunization record **MUST** accompany this application.

Returning campers - all we need is a record of any immunizations received since last at Camp Aldersgate. If your child has not received any new immunizations, disregard this section.

Applications submitted without the required immunization information cannot be processed until this information is received. Camp Aldersgate adheres to immunization guidelines used by most educational facilities.

Please check with your school nurse or administration about obtaining a copy of your child's record.

Camper Name:_____ Date of Birth:_____

HEALTH HISTORY AND PHYSICIAN'S AUTHORIZATION

The Health History and Physician's Authorization ***(both sides of this form)*** *is to be completed by the applicant's Primary Care Physician. It will be used by the camp's medical staff to determine medical eligibility, be reviewed by the camper's counselors, and will be kept on file in the infirmary.*

Dear Physician,

Camp Aldersgate's Camping Programs feature 3 to 6 days of traditional camping activities for children with medical conditions, physical disabilities, and developmental delays. Accepted applicants will be assigned to live with 6 to 8 cabin mates as well as junior and senior counselors. Activities may include nature hikes, canoeing, fishing, swimming, SCUBA, archery, campfires, music, adventure/challenge (ropes course) activities, arts and crafts. Although activities have been adapted so children of all abilities can participate, they may require physical exertion and/or travel to and from various locations throughout the camp.

Please complete both sides of this form. Attach additional information you feel the camp medical staff should be aware of.

Primary Medical Diagnosis: *(if not applicable write "none")*_____

List any Secondary Diagnoses:_____

CURRENT MEDICATION(S) (please indicate if pill, inhaler, injection, etc.)	STRENGTH	DOSAGE	TIME(S)			
			breakfast	lunch	dinner	other

ALLERGY INFORMATION

Is this child allergic to any:

Medications	Name	Reaction (be specific)	Age of last reaction
Foods	Name	Reaction (be specific)	Age of last reaction
Animals	Name	Reaction (be specific)	Age of last reaction
Insects			
Plants			
Other	Name	Reaction (be specific)	Age of last reaction

Is this child latex sensitive? yes no

Camper Name:_____ Date of Birth:_____

Dear Physician,
Please complete both sides of this form. Attach additional information you feel the camp medical staff should be aware of.

Date of last tetanus shot:_____ height:_____ weight:_____

blood pressure: _____/_____ heart rate:_____ respiration rate:_____

PHYSICAL EXAMINATION			
Body System	normal	abnormal	If abnormal, please explain
HEENT			
Cardiovascular			
Respiratory			
Gastrointestinal			
Skeleto-muscular			
Genitourinary			
Other – please explain			

Please circle/write the appropriate information below

General: frequent ear infections heart defect/disease seizures bleeding/clotting disorders hypertension rashes/ringworm

comments regarding circled items:_____

Surgeries (specify):_____

Childhood Diseases: chicken pox mumps measles german measles other (specify):_____

For Female Applicants - Has this applicant menstruated? yes no If so, is her menstrual history normal? yes no

Special consideration:_____

Medical Equipment

wheelchair charger hearing aids dialysis cycler other:_____

Bi-PAP C-PAP ventilator inhaler hospital bed other:_____

Has Down syndrome been diagnosed in this applicant? yes no

If yes, is the applicant clear of Atlantoaxial Dislocation Condition confirmed by diagnostic x-ray? yes no

Restrictions/limitations on participation in any camp activities:_____

Additional Comments:

PHYSICIAN'S AUTHORIZATION

I have examined _____ within the past 6 months (date examined: _____) and in my opinion, his/her condition DOES NOT preclude his/her participation in an active camp program.

Physician's Printed Name:_____ Phone: _____/_____

Address:_____ City:_____ State:_____ Zip:_____

Licensed Physician Signature (or Advanced Practice Nurse/Registered Nurse Practitioner representing the physician):

X _____ Date:_____

DIABETES HISTORY

Name:_____ Date of Birth:_____

Pump Type:_____ Serial Number:_____

Can he/she bolus himself/herself? *Yes* *No*

Know site change schedule & procedure? *Yes* *No*

Comments:_____

_____

_____

Shots Who gives your child the insulin shot?_____

Can he/she draw up the insulin himself/herself? *Yes* *No*

Administer his/her own shot? *Yes* *No*

Comments:_____

_____

_____

Insulin

Time:_____ Type: _____ Amount:_____

Time:_____ Type: _____ Amount:_____

Time:_____ Type: _____ Amount:_____

Time:_____ Type: _____ Amount:_____

Reactions

Hypoglycemia: *Yes* *No*
(Low Blood Sugar)

Can he/she tell when blood sugar is low? Yes No usual time of occurrence:_____

How does he/she act?_____

seizures? *Yes* *No* type:_____ duration:_____

Hyperglycemia: *Yes* *No*
(High Blood Sugar)

Can he/she tell when blood sugar is high? Yes No usual time of occurrence:_____

How does he/she act?

seizures? *Yes* *No* type:_____ duration:_____

Testing

Does your child test his/her own urine for Ketones? *Yes* *No*

Does your child test his/her blood glucose? *Yes* *No*

General testing results:_____

DIET INFORMATION

Name:_____ Date of Birth:_____

What is our child's average carb count per meal?_____ Per snack?_____

When did you receive this diet?_____

Where & by whom?_____

List all food allergies:_____

_____

_____

_____

Who is your current dietician?_____

Phone Number:_____ City:_____

When did you last see him/her?_____

My child knows:
- His/her own plan
- Diabetic exchange groups
- Basic do's and don'ts of diet
- Carbohydrate counting

Is there any other information the dieticians would find helpful about your child's diet?_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

CAMPER CODE OF CONDUCT

(Please review with your child)

It is our hope that everyone that participates in our program will have a positive experience that will last a lifetime. To help everyone get the most out of their camp experience, we have set up a list of ground rules to help parents and children understand what we expect at camp. We recognize the special needs of our campers and will, as much as possible, individualize the rules according to the needs and abilities of each camper.

Camp has four basic rules that we explain to the children and also post in the cabins. We have these rules so that everyone can be assured of a positive experience.

- Respect yourself, others and property. Abusiveness toward others or using inappropriate language, fighting, stealing, etc. is not allowed. It also covers property damage, graffiti or vandalism. Respect yourself, refers to keeping your things picked up, personal hygiene and taking your medication on time.

- Participate in camp activities. It is camp's responsibility to know where all the campers are at all times. We encourage campers to try all activities unless excused by staff. Campers are supervised at all times and cannot be left alone.

- Follow directions. There are a lot of fun things to do at camp but every activity has rules so we can operate the activity safely and appropriately. We ask the campers to follow staff direction during these activities.

- No put-downs. Examples of this would include teasing, name-calling, racial slurs or inappropriate practical jokes.

If we do have a problem with inappropriate behavior, we have a camper behavior response policy. The counselor will start by giving the child a warning, and then a time-out with an explanation and discussion on what is causing the problem. If the counselor needs help, a supervisor or coordinator on site will work with the child to help avoid further problems. We will also call home to find out if the parents have any suggestions on ways to deter the inappropriate behavior. As a last resort, we may need to send a child home. Sometimes in the case of severe homesickness or if misbehavior could cause immediate harm to themselves or others, we reserve the right to immediately ask that the child be removed from camp.

It is our hope that each child will go home with great memories of camp. These rules are designed to protect the camper's experience so that one unruly child won't ruin the experience for the rest. If you have any questions or comments, please feel free to call. It is our mission to provide a quality experience for everyone.

I understand and accept that my child must abide by the Camper Code of Conduct

Parent's Signature _____ Date _____

I _____ agree to abide by the Camper Code of Conduct

Camper's Signature _____ Date _____

American Diabetes Association. | Camps

Dear Camp Parent or Guardian,

We are looking forward to another great year at the American Diabetes Association's Diabetes Youth Camp at Camp Aldersgate. We are glad you are submitting your application and hope that your camper is excited about the fun times that are planned for the week.

To make the application process run smoothly and go as quickly as possible, please complete the camp application for Camp Aldersgate at www.campaldersgate.net. It is also required that you complete the following forms for the ADA:

- ADA Camp Social Media Release (1 Page)
- ADA Prospective Camper Consent Form (2 pages)
- ADA Camp Financial Assistance Application (2 pages) This form is required even if you aren't applying for financial assistance.

Please scan and email or mail the completed and signed forms to:

Camp Aldersgate
2000 Aldersgate Road
Little Rock, AR 72205
blyle@campaldersgate.net

The final application deadline to be considered for placement is May 16. Priority in camper placement will be given to those who have completed and returned their application IN FULL to Camp Aldersgate by April 10.

If you have any questions, please feel free to contact me any time at 913-383-8210 ext. 6848 or lfurstner@diabetes.org. I am looking forward to seeing you in July!

Sincerely,
Lora Furstner
American Diabetes Association
Regional Camp Director – Heartland Region

American Diabetes Association's Diabetes Camp at Camp Aldersgate
CAMP Financial Assistance Application (Page 1 of 2)

This form MUST be turned in even if you are NOT requesting financial assistance.

_____ **I am NOT requesting financial aid and agree to pay camp fees ($675) in full**. (Go to "signature" at the end of this form.)

_____ **I am requesting financial aid.** (This application must be completed in its entirety.)

Please print all information:

NAME OF CAMPER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE DIAGNOSED _____ DATE OF BIRTH _____

NUMBER OF YEARS CHILD HAS ATTENDED CAMP, IF APPLICABLE: _____

FATHER'S NAME: _____

ADDRESS (if different than camper): _____

CITY: _____ STATE: _____ ZIP: _____

PLACE OF EMPLOYMENT: _____

HOME TELEPHONE: _____ WORK TELEPHONE: _____

MOTHER'S NAME: _____

ADDRESS (if different than camper): _____

CITY: _____ STATE: _____ ZIP: _____

PLACE OF EMPLOYMENT: _____

HOME TELEPHONE: _____ WORK TELEPHONE: _____

Are there any extenuating or special circumstances that you would like us to consider?

American Diabetes Association. | Camps

CAMP Financial Assistance Application (Page 2 of 2)

List other persons living in your household for whom you provide financial support but do not claim on your taxes.

NAME	RELATIONSHIP TO CAMPER	AGE	STATUS – please circle
_____	_____ Other	_____	Employed Student
_____	_____ Other	_____	Employed Student
_____	_____ Other	_____	Employed Student
_____	_____ Other	_____	Employed Student
_____	_____	_____	Employed Student Other

PLEASE NOTE: This application is not a camp registration form to attend camp. This is to request financial assistance only.

Have you submitted a Camp Application?
YES NO

***Note: You must be registered for camp in order to apply for financial assistance**.

Please state the amount you are able to pay towards the Camp Resgistration Fee **(Camp Fee: $675)**:
$_____

You will be notified by the American Diabetes Association as to the status of your request for financial assistance and any amount awarded.

Please remember to include a signed copy of your *1040, 1040-A or EZ tax form or proof of yearly income with this application. Your request for financial assistance cannot be considered without it.*

If you have questions regarding financial assistance please contact Taylor Anderson-Beaver at tanderson-beaver@diabetes.org or 888-342-2383 ext. 6592

American Diabetes Association. | Camps

Prospective Camper CONSENT FORM (Page 1 of 2)

- I hereby apply for admission of my child (name) _____ to the summer Camp for children with diabetes operated by the American Diabetes Association ("Association").
- I understand my child shall be subject to the same Camp rules as the other children at Camp.
- I consent to my child receiving any and all medical care, treatment and testing the Camp's health care provider in charge determines is medically necessary, in his or her sole discretion (including without limitation diet, insulin dosage and/or type 2 oral medication and daily blood glucose monitoring). I consent to my child receiving any other necessary medical care, treatment, and testing the Camp health care provider in charge may cause to have performed by a licensed health care provider, emergency medical personnel at any facility, clinic or hospital while my child is a Camp participant, including without limitation tuberculin test and x-ray if the test is positive, and blood testing for Hepatitis B and/or HIV antibodies, in the event of an accidental needle stick where there may be possibly contaminated material (such as a syringe needle or lancet). I agree that I am personally responsible for any and all medical charges and expenses resulting from the treatment of my child either on the Camp property or at an off-site facility and that my insurance, if any, shall be the primary insurance coverage.
- I further consent to the release of any and all test results to the Public Health Authorities, if such release is required by any law, statute, or regulation.
- I freely give permission to my child's health care providers (including without limitation physicians, physician's assistants, clinical nurse practitioners, R.N.s, R.D.s, certified diabetes educators, therapists, psychologists, etc.) to release any and all information pertaining to my child to the Association, and any third party health care providers or institutions the Association deems medically necessary to treat my child during the Camp session. This consent expires at the end of the Camp session or the last day any necessary paperwork arising from the treatment of my child is complete, whichever date is later, and may be revoked at any time by giving written notice to the Association.
- I hereby grant my consent and permission for my child to leave the premises of the Camp on occasional trips to nearby points of interest under the supervision of the Camp Staff.
- I understand that while the Association may supply insulin, syringes, monitoring supplies and routine first aid care required at Camp, I shall be primarily responsible for the cost of all other medical treatment of my child, including but not limited to laboratory tests, x-rays, and emergency treatment at a hospital or clinic.
- I understand that the Association is not responsible for any damage, maintenance, repair or replacement of any durable medical equipment (including insulin pumps, continuous glucose monitors, hearing aids) my child may use during Camp, and other risks assumed in the use of such devices.
- I hereby waive, release and shall indemnify the Association against any and all claims, injury, damages or liability which may arise from my child's use of any durable medical equipment including without limitation misuse, malfunction or medical care in connection with such durable equipment.
- I understand that the purpose of the continuous glucose monitor is to show trends and not to adjust insulin. No alterations in my child's medical plan will be made based solely on CGM readings/warnings (alarms) without discussion with and approval of Camp medical staff directly responsible for my child's care.
- In order to assist in the prompt treatment of my child, I hereby consent to any necessary medical or surgical treatment and testing of my child of an emergency nature and my child receiving off-site medical care at the closest available medical facility. Below my signature, I have listed the policy number for any applicable policies of hospitalization insurance that I carry on this child (including Medical Assistance). I authorize the appropriate representative of the Association to release the information concerning my hospitalization insurance to any provider of medical or surgical services to my child.
- **IN CONSIDERATION OF THE AMERICAN DIABETES ASSOCIATION ALLOWING MY CHILD TO ATTEND ITS SUMMER CAMP, I HEREBY KNOWINGLY WAIVE AND RELEASE THE AMERICAN DIABETES ASSOCIATION, ITS AGENTS, EMPLOYEES, ASSIGNS, VOLUNTEERS, DIRECTORS, OFFICERS AND MEDICAL STAFF (COLLECTIVELY, "THE ASSOCIATION"), FROM ANY AND ALL LIABILITY OR CLAIM ARISING OUT OF AND IN CONNECTION WITH MY CHILD'S PARTICIPATION IN CAMP FOR ANY REASON.**
- I have read and am aware of and shall abide by the Camper Pick-Up policies.

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Prospective Camper CONSENT FORM (Page 2 of 2)

Please check and initial one of the two following statements:

_____ (Initials) I do consent to participate and have my child's name, my name, address, and email address placed in a Camper/Parent Directory that is given to each camper.
I agree to 1) use this information solely for my personal use and not to forward, share, distribute or otherwise cause it to be used by a third party and 2) waive and release the Association from any claims I may have against the Association and 3) agree to defend and hold the Association harmless against any claims caused by my acts or omissions in connection with the use or misuse of the Camper/Parent Directory.

_____ (Initials) I do not consent to the placement of my child's or my name, my name address, and email address in a Camper/Parent Directory that is given to each camper.

_____ (Initials) Further, I have read, and fully understand and I knowingly agree to the terms of this Consent Form.

_____ _____ _____ _____
Signature of Father/ Mother Date Signature of Legal Guardian Date

The following information is for hospital / immediate care center billing purposes only:

Insurance Company _____Policy Number _____ Group Number _____

Policy Holder Information: Name _____ Birth Date_____
SSN_____

Child's Information: Name _____ Birth Date_____
SSN_____

The following information is for hospital / immediate care center billing purposes only:

Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder Information: Name _____

Birth Date: _____ SSN: _____

Child's Information: Name: _____

Birth Date: _____ SSN: _____

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Camp Social Media Release

Date: _____

Camper Name: _____ Camper's Date of Birth: _____

I hereby irrevocably grant to the American Diabetes Association, its successors and assigns, and to such other persons as the American Diabetes Association may designate from time to time, the absolute (perpetual), world-wide, transferable, royalty-free right and permission to capture and use the above named Camper's likeness, name, picture, image, voice, writings or other creative works ("Personal Elements") in video and photographs, in whole or in part, together with or without written or spoken copy for publicity, public education, and any other lawful purpose of the American Diabetes Association and in any and all formats, including without limitation digital, social media and those not now known and may be developed in the future in connection with my participation in the **American Diabetes Association' Diabetes Camp At Camp Aldersgate.**

I hereby waive the right to inspect versions of images used for publication or the written copy used in connection with the images generated from the Event.

I hereby release, discharge, and agree to hold harmless the American Diabetes Association and all other persons using my name, likeness, photographs and video footage from any liability whatsoever from the use of my Personal Elements in accordance with the terms hereof, including but not limited to, any liability for what might be deemed to be misrepresentation or defamation of me, my character or my person due to the distortion, alteration, optical illusion or faulty reproduction which may occur in the development of use of my Personal Elements in visual works, or any written or spoken material which is part of or connected with my Personal Elements.

I understand that I have the right to revoke this Authorization at any time by giving written notice of the revocation. I understand that any revocation will not apply to any disclosure that has already been made in reliance upon this authorization.

I hereby understand that I have the right to refuse my Authorization and that my refusal will not affect my child's ability to receive treatment, get payment for treatment, or attend camp.

I have read and fully understand this waiver and in consideration of the acceptance of participation in the Camp or Event, for the Camper names above, I waive and release the American Diabetes Association, its employees, directors, officers, volunteers, agents, successors and assigns, and all sponsors, from any and all claims, liabilities or causes of action, including without limitation, death, bodily injury, property damage, or any other loss, damage or any inconvenience whatsoever, arising from my participation in the Camp or Event and the subject matter of this Release..

[ ] I hereby authorize the American Diabetes Association to the release the above named Camper's Personal Elements as described above.

[ ] I do not authorize the American Diabetes Association to the release the above named Camper's Personal Elements as described above.

Parent or Guardian's signature required if Participant is under 18 years of age:

Custodial Parent / Legal Guardian Name (please print): _____

Custodial Parent / Legal Guardian Signature: _____

NOTE: All information submitted to the American Diabetes Association will be kept private and confidential.