CAPE FEAR VALLEY
KIDS with DIABETES
101 Robeson Street, Suite 410
Fayetteville, NC 28301
Tel. 910-615-1885
Fax 910-321-6254

Office Only: Date Received: _____Payment Received: _____

Camp Fee ☐Early Registration ($250) ☐Late Registration ($300)

Group Name: _____Counselor: _____

Room: _____

Diabetes Camp 2024

Thursday June 20th – Sunday June 23rd, 2024 Ages: Kids with diabetes 6-18

CAMP LOCATION: Camp Rockfish at 226 Camp Rockfish Rd, Parkton NC 28371.
DROP OFF: 6 pm on Thursday June 20nd
PICK UP: 12 pm on Sunday June 23rd **(There will be a charge of $1.00 for every minute late)**
CAMP FEE: Early registration prior to Friday May 26th, 2024, **$250**
Late Registration May 27th –Sunday June 2nd **$300**

HOW TO SIGN UP
There are two ways to sign your camper up:

1. Complete the Camp Application Form below and return it to our office in person, by email, or fax.
   - Our address is: 101 Robeson Street, Suite 410 Fayetteville, NC 28301
   - Our fax is 910-321-6254
2. Download Online Application:
   - **Sweetkidswithdiabetes.com**, pay for registration and fax/email Registration to us. Email **aross2@capefearvalley.com**

All applications due by Sunday, June 2, 2024. Registration may close early if we reach full capacity.
We will not accept applications turned in after Sunday, June 2nd . *NO EXCEPTIONS WILL BE MADE*!

Camp Application Form

Camper's Name: _____

Camper's Date of Birth and Age at Start of Camp: _____

Address: _____

City: _____ State: _____ Zip Code: _____

1. **List any allergies and symptoms to medications or foods of allergic reaction(s)?**

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

Medication Name	Time Given	Dose	Reason for Taking

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

_____

_____

_____

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

5. **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						

6. **We must have phone number(s) where parent/guardian can be reached for the entire camp session.**

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

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

Name: _____

Relationship: _____

Phone: _____

To be completed by Pediatric Endocrinologist or Primary Provider:

Child's Name & Date of Birth: _____

Report of Physical Examination (circle one): Yes No

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

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: _____

Insulin Pump ____ Medtronic ____ Omni Pod ____T-Slim ____Ilet Bionic Pancreas

Carbohydrate Dose

☐ Use a Carbohydrate Ratio
Meals: 1 unit per _____ grams
Snacks: 1 unit per _____ grams

☐ Use a Fixed Dose
Breakfast _____units
Lunch _____units
Dinner _____units
Snacks _____units

Correction Dose

☐ Use Insulin Correction Factor
1 unit for ea. _____>_____ mg/dl

☐ Use sliding scale
150-199 give ___ units 350-399 give ___ units
200-249 give ___ units 400-449 give ___ units
250-299 give ___ units 450-499 give ___ units
300-349 give ___ units ≥ 500 give ___ units

For Pumps Only
Basal Rates

Time	Units/Hour

Metformin Dose and Frequency: _____

Other Diabetes Medication Name, Dose, Frequency: _____

Date of Examination: _____ Signature of Examiner: _____

Print Name of Examiner: _____

Address: _____

Phone: _____ Fax: _____

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): _____