



Dear Camp Carolina Trails Applicant:

The 2008 session of Camp Carolina Trails will be held June 15-21 at YMCA Camp Hanes in King, North Carolina. We are looking forward to a great week of fun and adventure.

Campers must be entering the 4th through the 11th grade in Fall 2008 to be accepted into Camp Carolina Trails. Every camper must submit each of the following forms before their application can be considered:

Online Application Form	Camper and parents complete
Medical Information Form	Parents and doctor complete
Consent and Waiver Form	Parents complete
Self Care Questionnaire	Camper and parents complete
Nutrition Questionnaire	Camper and parents complete
HIPPA Form	Parents complete
Behavior Contract	Camper and parents complete

ALL SEVEN FORMS must be completed and returned to our office, along with a \$100 registration fee, before your application will be reviewed for acceptance into camp. The registration fee will be refunded ONLY according to the guidelines contained in this packet . The total fee for camp this year is \$600. A limited number of partial camperships are available to youth who demonstrate need. The amount of the campership is determined by the family's ability to pay. For a campership application, call the American Diabetes Association Office at 1-888-342-2383, Ext 3262 .

A baseline tuberculin test is recommended. Campers should review with their physician who should note the date and the result on the Medical Information Form and update the tuberculin test if needed.

Each camper must have received a tetanus vaccine since June 14, 1998 (indicate date of last vaccine on the Medical Information Form). This **must be** on the health form.

The deadline for submission of all forms and the \$100 registration fee is June 1, 2008; however, the camp fills quickly so you are encouraged to return the completed application forms as quickly as possible. **Please be sure that all forms are filled out completely, as any missing information may delay or prevent acceptance into camp.**

Return completed application forms to: Camp Carolina Trails
American Diabetes Association

222 South Church Street, Suite 336M
Charlotte, NC 28202

Information regarding acceptance will be mailed on a rolling basis . You will be notified by mail of acceptance to Camp Carolina Trails within two weeks of our receipt of your completed camper application. The remaining portion of the camp fee (\$500) will be due by **June 6, 2008** . If you have questions, you may call the American Diabetes Association Office at 1-888-342-2383, Ext. 3262. We look forward to receiving your completed application soon!

Sincerely,
Camp Carolina Trails Committee



HEALTH EVALUATION AND INFORMATION FORM

DEADLINE: This form should be returned with camp application and must be received before an applicant can be considered for acceptance to camp. The completed application including medical form **MUST** be received by June 1, 2008.

TO BE COMPLETED BY PARENT OR GUARDIAN

PERSONAL INFORMATION (CAMPER)

First Name _____ Last Name _____

Phone Number _____ Date of Birth _____

Camper's Primary Care Physician's Office _____

General Physician First and Last Name _____

Address _____

City, State, Zip _____ Phone () _____

Problems with insulin administration (i.e. problems with pump site)? _____

If you have a continuous glucose sensor, will you be using it at camp? _____

During the past year, has the camper been under the care of (please answer YES or NO to each)

School Counselor _____ Psychologist _____ Psychiatrist _____

Does the camper ever wet the bed? _____

If so, what intervention can you suggest? _____

HEALTH HISTORY/IMMUNIZATION RECORD (give dates of disease or year immunization completed; this record **MUST** be completed accurately and completely; date of last tetanus immunization must be later than 6/14/98);

All spaces must be filled in. We must have dates for immunizations and information regarding these illnesses and drug allergies. If not applicable, please fill in with N/A

Ear Infections _____ Insect Sting Allergy _____ Diphtheria/Pertussis/Tetanus (DPT) _____

Rheumatic Fever _____ Ivy Poisoning, etc. _____ Tetanus/Diphtheria (TD) _____

Convulsions _____ Asthma _____ Polio (Salk or Sabin) _____

Behavior _____ Drug Allergies: _____ MMR 1 _____

(Measles, Mumps, Rubella)

Hay Fever _____ Penicillin _____ MMR 2 _____

Chicken Pox _____ Other Drugs _____ Hepatitis B _____

Operations or serious injuries (include dates) _____

Chronic or recurring illness other than diabetes _____

Other diseases or details of above _____

NOTE: You will be notified, as soon as reasonably possible, if your child is taken out of camp for medical care (emergency room or the urgent care facility).

I verify that the above information is complete and correct _____

Signature of Parent or Guardian and Date

This form **MUST** be filled out completely and must have the physician's signature. Without these things, the child cannot be considered as an applicant.

TO BE COMPLETED BY LICENSED PHYSICIAN

HEALTH EVALUATION FOR (NAME) _____ **Date of Examination** _____

This examination should be performed within the 12 months prior to June 14, 2008. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Ht _____ Wt _____ BP _____ HbA1C (Date) _____ Result _____

A baseline tuberculin skin test (TST) is recommended. Update if there have been any risks for TB exposure (such as living in an endemic country, exposure to a person with TB).

Tuberculin Test- Date _____ Result _____

CODE: / Satisfactory X Not Satisfactory 0 Not Examined



Eyes Lungs Allergies - Please Specify
 Glasses Abdomen
 Ears Hernia
 Nose Extremities General Appraisal
 Throat Posture (Spine)
 Teeth Skin
 Heart Other
 Please explain any X above

Does this patient have any physical disabilities other than diabetes? _____ Yes _____ No
 If yes, please specify _____

What medications (other than insulin) does the camper use?

Are there factors which would limit this patient's ability to benefit from camp? _____

Do you have special instructions or restrictions while at camp? Please describe fully.

Does this patient have any behavioral problems? _____
 Has this patient been hospitalized in the last 12 months? _____; If so, explain _____

Consider this patient's other resources for recreation, peer relationships, diabetes teaching, etc. Which of the following do you feel pertains?
 ___ Camp is very urgently needed ___ Camp is urgently needed ___ Camp would be helpful but isn't urgently needed

I have examined the person herein described on the date indicated above and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities except as noted above.

 Name of Examining Physician (please print) Examining Physician's Signature

 Address Telephone

 City, State, Zip Date



Nutrition Questionnaire 2008

Camper's name _____ Nickname _____

Primary Parent/Guardian Home Phone _____ Email _____

Yes

Camper has food intolerance or allergies. (Please list) _____

Camper requires a Gluten-Free diet—please attach list of camper's usual foods for meals/snacks

At meals, does your child need help No help needed Needs help

with:

Counting the number of carbs

eaten

Giving the right amount of

insulin

We need an idea of how much your child usually eats. My child's diet can be described as:

_____ Insulin is given based on how many carbs are eaten: _____ Units Insulin to _____ grams carbohydrate

Please indicate the usual range of carbs on Pattern A below (example: 25-50 gms)

_____ Consistent carbs are eaten. Please complete Pattern A below

_____ Other. Please describe _____. Please complete Pattern B below.

Pattern A: Carbohydrate counting

Pattern B: Typical Intake

Estimate portions in measuring cups or level tablespoons. Please enter actual foods rather than "meat", "vegetable"...

Be as exact as you can. Include condiments, sauces, margarine/butter.

Amount	Food	Amount	Food
Breakfast		Morning Snack	
Lunch		Afternoon Snack	
Dinner		Bedtime Snack	

How many hours per day does your child spend in:

VIGOROUS activity (basketball, swimming, bicycling, running) _____ hours per day

MODERATE activity (walking, playing outside with friends, shopping) _____ hours per day



Camp Carolina Trails Self Care Questionnaire- 2008

First Name _____

Last _____ DOB _____ Age _____

Date Diabetes Diagnosed _____ Type (circle one): 1 2

ORAL MEDICATIONS Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Time(s) _____ Name: _____ Dose: _____

Please indicate the brands and types of insulin and diabetes supplies you use. Look on the packaging for the information

Please Circle All That Apply:

INSULIN-- Brand: Novo Lilly Aventis
Type: NPH Lantus Regular Humalog Novolog 70/30 75/25 50/50 Apidra Levimir
Packaging: Cartridge of -- Pre-filled pen of Vial (s) of

PUMP – Animas Cozmo Minimed Omnipod Other Pump _____

Type of Infusion Set _____ ******Please bring your own pump and monitoring supplies!!!**

GLUCOSE METER - One touch -Ultra Accucheck Advantage-Compact-Aviva Ascencia -Breeze--Contour
BD Logic-Link Freestyle-Freedom, Lite Cozmonitor Other
Meter _____

INJECTIONS TIME / UNITS / INSULIN TYPE		INSULIN PUMP BASAL RATE	
_____ time / _____ units / _____ insulin type	_____ units	from _____ to _____	
_____ time / _____ units / _____ insulin type	_____ units	from _____ to _____	
_____ time / _____ units / _____ insulin type	_____ units	from _____ to _____	
_____ time / _____ units / _____ insulin type	_____ units	from _____ to _____	

Sliding Scale
_____ units if _____ grams carb Bolus dose(s) _____ units per
_____ units if _____ units if _____
_____ units if _____ units if _____
_____ mg/dl
_____ units if _____ units if _____

Correction Target : _____

Does the camper Give own injections? Yes No Draw up insulin? Yes No Check blood sugar? Yes No
Wear a Medi-Alert? Yes No



Carry sugar? **Yes No**
prime tubing? **Yes No**

Rotate pump site? **Yes No**

Change infusion set? **Yes No**

Change Cartridge and

How often do you check--Urine ketones _____ Blood glucose _____/day

Hypoglycemia - Do you know when you have a low blood sugar **Yes No**

Symptoms _____

Have you ever had a bad low-- required help from someone to treat a low, lost consciousness or needed Glucagon? **Yes No**

Please _____ describe

What is your target glucose range? _____ - _____ How often do you achieve it?

Last Hemoglobin A1C value: _____ date: _____

Are there any unusual circumstances that could cause the camper concern (i.e. divorce, illness etc.?)

Goal(s) for
camp _____

Person completing form _____ Reviewed by Parent / Guardian (signature)



**Camper/Parent Behavior Contract
Concerning Rules & Expectations at Camp**

I will stay on the property during the camping session.

I will not intentionally injure or endanger myself or any other person either physically or emotionally. This includes keeping my blood sugar extremely high or low on purpose.

I will respect the environment, Camp, property of Camp and personal property of others. If I do not, my family will be responsible for damages caused.

I will not use bad / inappropriate language.

I will not engage in any sexual contact or use language of a sexual nature

I will not use tobacco products, drugs, alcohol, or weapons.

I will demonstrate respect for staff and fellow campers at all times.

I will not engage in teasing, harassment or ethnic /racial /religious/political slander of any person or group.

If I am with someone who is breaking one of the above rules, I can also be dismissed.

If I do not follow these rules, I

- 1) Can be promptly dismissed from Camp.
- 2) Must have parent/guardian come to Camp to pick me up.
- 3) Forfeit all Camp fees.
- 4) Risk losing the privilege of returning to Camp in the future.

I have read and understand the rules and will help enforce them. In addition, I have read and explained the Camp rules to my child and believe that he/she understands them. I agree to pick my child up from Camp if he/she breaks this contract.

I will treat all campers and staff during and after Camp with respect. This means that I will not participate in any phone, online, email, instant messaging or text messaging of a threatening, bullying or inappropriate nature. If I do, I may not be allowed to attend Camp.

Camper Signature

Parent/Guardian Signature

Date

Date



Prospective Camper CONSENT FORM

- I hereby apply for admission of my child (name) _____ to the summer Camp for children with diabetes operated by the American Diabetes 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 medically necessary medical care, treatment, and testing the Camp diabetes 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 finger prick 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 plan.
- 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 American Diabetes Association, and any third party health care providers or institutions the American Diabetes Association deem 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 anytime by giving written notice to the American Diabetes 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 American Diabetes 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 ADA 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 ADA 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 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 American Diabetes 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, 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.



Please check and initial one of the two following statements:

_____ I do consent to the placement of my child's name, address, phone number and email address in a Camper Directory that is
Initials _____ given to each camper.

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

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

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 _____



**AMERICAN DIABETES ASSOCIATION
APPLICATION FOR CAMP FINANCIAL ASSISTANCE**

This application must be completed in its entirety. **PLEASE PRINT**
Please attach a copy of your most recent 1040, 1040-A or EZ tax form.

NAME OF CAMPER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE _____

DATE DIAGNOSED _____ DATE OF BIRTH _____

NUMBER OF YEARS CHILD HAS ATTENDED CAMP: _____

FATHER'S NAME: _____

ADDRESS (if different) _____

CITY: _____ STATE: _____ ZIPCODE _____

PLACE OF EMPLOYMENT: _____

HOME TELEPHONE: _____ WORK TELEPHONE: _____

MOTHER'S NAME: _____

ADDRESS (if different) _____

CITY: _____ STATE: _____ ZIPCODE _____

PLACE OF EMPLOYMENT: _____

HOME TELEPHONE: _____ WORK TELEPHONE: _____

TOTAL ANNUAL INCOME: FATHER: _____ MOTHER: _____

Please attach a copy of your 1040, 1040-A or EZ tax form.

Are there any extenuating or special circumstances that you would like considered when your application is reviewed?



OTHER DEPENDENTS IN HOUSEHOLD	RELATIONSHIP TO CAMPER	AGE	STATUS – please circle		
			Employed	Student	Other
_____	_____	_____	Employed	Student	Other
_____	_____	_____	Employed	Student	Other
_____	_____	_____	Employed	Student	Other
_____	_____	_____	Employed	Student	Other
_____	_____	_____	Employed	Student	Other

NAME OF CAMP APPLIED TO: _____

ADDRESS OF CAMP: _____

CITY: _____ STATE: _____ ZIPCODE _____

DATE/SESSION OF CAMP: _____

PLEASE NOTE: You must complete a separate registration form to attend camp in addition to this application for financial assistance.

PREVIOUS CAMP ATTENDANCE AND SPONSORSHIP:

CAMP: _____ DATE: _____ Financial Aid Given YES NO

CAMP: _____ DATE: _____ Financial Aid Given YES NO

CAMP: _____ DATE: _____ Financial Aid Given YES NO

CAMP: _____ DATE: _____ Financial Aid Given YES NO

HAVE YOU SUBMITTED A CAMP REGISTRATION FORM FOR THE ABOVE CAMP?

YES NO

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

PLEASE STATE THE AMOUNT YOU ARE ABLE TO PAY TOWARDS THE CAMP REGISTRATION FEE:

\$ _____

I (MY CHILD) WOULD LIKE TO ATTEND CAMP BECAUSE: (Use reverse if needed)

ARE YOU/YOUR CHILD A MEMBER OF THE AMERICAN DIABETES ASSOCIATION?

_____ YES _____ NO

If NO, would you like to receive membership information? _____

You will be notified by the American Diabetes Association if you qualify for total or partial financial assistance. Please submit your camp application to the camp with a notation that you have applied to the American Diabetes Association (ADA) for aid. We will advise you and the camp of the financial aid decision.



CAMP REFUND POLICY

The American Diabetes Association strives to control the costs associated with providing camp in order to keep the fee families pay as reasonable as possible. ADA underwrites the cost of every camper by at least 50% of the fee that is charged to families.

In order to provide the camp program, ADA must contract and pay for the procurement of staff, a camp facility and all supplies up to 10 months prior to camp. We must pay all expenses for a guaranteed number of campers regardless of the number that actually attend. Therefore, this policy is to ensure that we can continue to make camp affordable for families, continue providing financial assistance to families who need it, and have time to fill vacancies from the camp waiting list.

Camp Committee unable to place camper in a session:

Refund of Camp Fee & deposit

Camper Cancels after being accepted:

- a. Written cancellation received 60 days prior to camp opening day.
Refund of Camp Fee less non-refundable deposit
- b. Written cancellation received 59 to 30 days prior to camp opening day.
Refund of 50% of Camp Fee less non-refundable deposit
- c. Written cancellation received 29 to 15 days prior to camp opening day:
Refund of 25% of Camp Fee less non-refundable deposit
- d. Written cancellation received 14 days or less prior to camp opening day:
No refund of Camp Fee or non-refundable deposit.
- e. Serious Illness or death in family:
Refund of Camp Fee less non-refundable deposit

Opening Day:

- a. Camper not accepted due to condition found by camp physician during camp opening day health screening.
Refund of Camp Fee less non-refundable deposit
- b. Camper not showing on opening day.
No Refund of Camp Fee or non-refundable deposit



Early Departure of Individual Camper from Camp:

- a. Illness during camp; camp physician recommends camper returns home.
Refund of Camp Fee prorated less non-refundable deposit
- b. Illness during camp; camp physician recommends camper can remain in camp, but parent elects to withdraw camper.
No Refund of Camp Fee or non-refundable deposit
- c. Serious Illness or death in family, camper removed at parent's request.
Refund of Camp Fee prorated less non-refundable deposit
- d. Camper elects to leave camp early (camper homesick; camper wanting to return home for various reasons).
No Refund of Camp Fee or non-refundable deposit
- e. Camper sent home for reasons determined appropriate for protection of said camper, other campers or staff.
No Refund of Camp Fee or non-refundable deposit

Early Closure of Camp because of Shortened Session due to Fire, Epidemic, or Natural Disaster:

- a. During the first half of camper session.
One-half of camp fee paid will be refunded less non-refundable deposit
- b. During the last half of camper session.
No Refunds will be made
- c. Camp closed prior to session due to above.
Refund of camp fee less non-refundable deposit

Late arrival or camper absence during camp session:

No Refund of Camp Fee or non-refundable deposit



AMERICAN DIABETES ASSOCIATION
AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

HIPAA (Health Insurance Portability and Accountability Act)

Camper Name: _____

Camper's Date of Birth _____

Name of Custodial Parent /Legal Guardian _____

- I hereby authorize the American Diabetes Association (ADA) to release the above named Camper's Personal Health Information (PHI) as described below:

The purpose of this disclosure is to promote the ADA Camp program, publicize the ADA Camp program, and/or fund-raise for the American Diabetes Association:

Check all to which you agree.

The PHI to be disclosed is limited to the following:

Camper photograph or likeness

I would like my child and I to receive a username and password for access to ADA's Camp Web pages for ongoing communication with Camp staff and campers.

Other (please specify) _____

The PHI may be disclosed as part of the American Diabetes Association's marketing efforts, including but not limited to, mailing list development for Camp, a brochure promoting Camp or other educational program, or fundraising events of the American Diabetes Association.-

Expiration date: This Authorization shall expire on December 31, 2018.

Right to Revoke: I understand that I have the right to revoke this Authorization at any time by giving ADA 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 understand that I have the right to refuse to sign this Authorization and that my refusal will not affect my child's ability to receive treatment, get payment for treatment, or attend camp.

I understand that I will be given a copy of this signed Authorization.

A copy of this document is valid as an original. The original is not required to be shown.

Custodial Parent's/Legal Guardian's Name (print)

_____/_____
Custodial Parent's/Legal Guardian's Signature / Date

Relationship to Camper



AUTORIZACIÓN PARA COMPARTIR INFORMACIÓN DE SALUD PERSONAL
HIPAA (Health Insurance Portability and Accountability Act)

Nombre del Participante: _____

Fecha de Nacimiento del Participante _____

Nombre del Padre con la Custodia /Guardián Legal _____

- Autorizo a American Diabetes Association (ADA) a compartir información de salud de la persona anteriormente mencionada según se indica a continuación:

El propósito de compartir la información es para promover o hacer publicidad al programa de campamento de American Diabetes Association, y/o recolectar fondos para American Diabetes Association:

La información de salud que se puede compartir está limitada a:

Foto del participante u otro documento de identificación

Quisiera que mi hijo/hija reciba un nombre de usuario y contraseña para tener acceso a las páginas Web de la ADA para tener constante comunicación con el personal y participantes del campamento.

Otro: (especifique _____)

La información de salud personal puede ser revelada como parte de los esfuerzos de mercadeo del American Diabetes Association, incluyendo, pero no limitada al desarrollo de una lista de contactos, panfletos de promoción del campamento y otro programa educativo, o eventos para recaudar fondos para American Diabetes Association.

Fecha de vencimiento: Esta autorización expira el 31 de diciembre del 2018.

Derecho a Revocar: entiendo que tengo el derecho a revocar esta Autorización en cualquier momento por medio de una notificación escrita a American Diabetes Association. Entiendo que cualquier revocación no aplicará a información que haya sido compartida previamente con relación a esta autorización.

Entiendo que tengo el derecho de negarme a firmar esta Autorización y que hacerlo no tendrá ningún impacto sobre los derechos de mi niño para recibir tratamiento, recibir pagos para tratamientos, o asistir al campamento.

Entiendo que se me dará una copia de la Autorización firmada.

Las copias de este documento son tan válidas como su versión original. No se requiere que se presente el documento original.

Nombre del Padre con la Custodia/ Guardián Legal
(imprima)

_____/_____
Firma del Padre con la Custodia/ Guardián Legal / Fecha

Relación con el Participante