

# CAMP ADAM FISHER

Dear Camper and Parents:

Welcome to Camp Adam Fisher 2010, June 6th - June 12th. Our staff works on camp all year to ensure safe, fun activities and memorable adventures. We are the Carolina's largest camp for children with diabetes, their friends and siblings and healthy diabetes management is incorporated in all aspects of our camp.

Camp Adam Fisher is a not-for-profit camp staffed completely by volunteers including Pediatric Endocrinologists, Pediatricians, Nurses, Certified Diabetic Educators, Registered Dietitians and specially trained Counselors. "Counselor In Training" positions are available for campers age 15 and older. Please complete the CIT packet found at [campadamfisher.com](http://campadamfisher.com) when you return your camper application, which will also include a reduced tuition rate. We hope you will begin making plans early to attend this year's camp as spaces are limited and will be reserved on a first-come basis.

This years camp tuition remains only \$595 which includes food, lodging, activities, diabetic supplies and medical coverage 24 hours a day for the entire week of camp, after the April 23rd deadline we will except the late tuition of \$695 until May 7th. A \$100 non-refundable deposit will hold a space for your child. The balance will be due no later than April 23rd. *Please keep in mind, no money will be collected at camp.*

With the large number of campers that we serve, financial aid is available, but limited. Any questions regarding this year's camp or requests for financial aid should be made by phone to our Program Director, Elizabeth Todd Heckel, at 803-434-2442. Financial Aid requests will be considered until April 23rd. ***Please remember only a complete camper application will hold your child's space not a financial aid application.***

An acknowledgement letter will confirm receipt of your child's application. Welcome packets will be mailed out starting the week of May 3rd. We look forward to hearing from all of our returning campers and are excited about meeting our new campers.

Remember: Please sign the Patient Consent Form on the last page of the application, and return all signed and completed forms by April 23rd.

**Mail all forms to:**

Camp Adam Fisher  
P.O. Box 5226  
Columbia, SC 29250

Thank You,  
The Camp Adam Fisher Family



## **Attention Campers!**

**Due to the high number of campers with diabetes we will not be able to except campers with Type 2 diabetes unless they are “insulin requiring”. If space permits we will create a waiting list for those Type 2 campers who do not require insulin and meet our camp guidelines established by our medical review team.**

**We are sorry for this inconvenience  
and thank you for your understanding.**



## Camper Application

*Please Print*

Child's Full Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Child's age as of June 1, 2010 \_\_\_\_\_

Does your child have Diabetes: Yes \_\_\_\_\_ No \_\_\_\_\_

How old was your child when they developed Diabetes: \_\_\_\_\_

This will be my child's \_\_\_\_\_ year at Camp Adam Fisher.

Does your child wear an Insulin Pump: Yes \_\_\_\_\_ No \_\_\_\_\_

Type of Insulin Pump \_\_\_\_\_

Mailing address for all camp correspondence: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent E-mail address \_\_\_\_\_

Are parents or guardian in the military: \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes please explain: \_\_\_\_\_

Home phone:(\_\_\_\_) \_\_\_\_\_ Emergency phone:(\_\_\_\_) \_\_\_\_\_

**If you have requested financial aid** – Which organization have you

requested aid from: CAF \_\_\_\_\_ CCC \_\_\_\_\_ Other \_\_\_\_\_

Amount requested: \$ \_\_\_\_\_ Please remember it is your responsibility to ensure that we receive all the necessary information.



## Camper Behavioral Agreement and Contract

Our camping program is designed to provide a safe, educational atmosphere for you and your friends to have a fun time. We want you to be more knowledgeable about diabetes and better informed on making decisions. It is our desire that you will leave camp destined to become productive citizens with the desire to live your life to the fullest in a healthy way with diabetes. You will be responsible to your counselors and the other adult staff of the camp.

### Behavioral Contract

As a camper, I agree:

1. To assist my fellow campers with the activities of daily living.
2. To obey my counselors during daily schedules, and diabetes management.
3. To be responsible for unpacking and packing my clothing and keeping up with my clothing
4. To assist with cabin clean up and committee work.
5. To set an excellent example for my fellow campers.
6. To cooperate and obey all camp staff.
7. To participate in evening programs assigned by my counselors.
8. To be in my assigned activities places at all times, unless otherwise stated by my counselors or camp staff.
9. To abide by all camp rules established by the Camp Committee.
10. To **Never** Be Alone.

If you violate the behavioral guidelines as stated above, you could be sent home with no refund of camp fees. If you feel you have been mistreated by others in camp, you can seek help from your counselors or the Management Staff.

I understand the rules and regulations and will conduct my behavior as stated.

Date \_\_\_\_\_

Camper's Signature \_\_\_\_\_

Parent's Signature \_\_\_\_\_



## CONSENT FOR PERMISSION TO OBTAIN HIV/HBV STATUS

The Occupational Safety and Health Administration in the Department of Labor (OSHA) requires by law that we perform measures to prevent any camper and staff from accidental exposure. An accidental exposure is defined as a situation when the staff or camper has been in contact with blood, body fluids or potentially infectious material from another camper or staff. If this happens at camp the law requires that all campers and Camp Adam Fisher staff persons involved must be tested. This test includes a blood test for HIV and Hepatitis B.

This blood test would be performed at no cost to you. The results will be given to you and to the medical team. We will not disclose the results of these tests to others except as required by law or as necessary to safeguard the well being of other health care workers involved in the medical care of the camper or other persons at risk. I understand that the results will be placed in the Camp Adam Fisher Exposure Control Records.

I give consent to the performance of a blood test to detect the HIV and Hepatitis B status of my child in the event of an accidental exposure.

*Name of Camper* \_\_\_\_\_

*Signature of Parent* \_\_\_\_\_

*Date* \_\_\_\_\_



## Diet History form

NAME \_\_\_\_\_ AGE \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_

MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

What kind of diet does your child follow? (Check all that apply):

Carbohydrate counting

Exchange list

Calorie level – (Please specify how many calories per day or grams of carbohydrates per meal)

Other

Does not follow any diet

If your child has a meal pattern, please specify below. If you do not follow a pattern, list foods that are typically eaten at the following times:

Breakfast

Lunch

Supper

Morning snack

Afternoon snack

Bedtime snack

Please list any food allergies:

What, if any, food related issues cause the most problems with your child's diabetes?

When, if any, is the hardest time of the day to keep your child's blood sugars in control?  
(Please explain)

How physically active is your child? (Please check one)

very inactive

moderately active

extremely active

Does your child play sports on a regular basis or is a member of a team? If so, please explain:

I have attended Camp Adam Fisher before?  Yes  No

If yes, how many years? \_\_\_\_\_

I am on an insulin pump?  Yes  No Name/Type of Pump: \_\_\_\_\_



## Photography / Publicity Release

Camper's Name: \_\_\_\_\_

I consent and authorize the designated staff of Camp Adam Fisher, Inc., their members, successors, assigns and nominees to use and reproduce the name, home address, home phone number, interviews, photographs, and video taken of my son/daughter named above while attending Camp Adam Fisher, held at Camp Bob Cooper, in Summerton, South Carolina, and to circulate the same for any and all promotions of all kinds in all media.

The undersigned does hereby release Camp Adam Fisher, Inc., their members, successors, assigns, and nominees, and any and all persons associated in any capacity with a summer camp known as Camp Adam Fisher from any and all claims for damages for libel, slander, invasion of the right of privacy, or any other claim based on the use of said material.

*Signature of Parent/Guardian:* \_\_\_\_\_

*Witness:* \_\_\_\_\_

*Date:* \_\_\_\_\_



## ***Release and Permission to Participate***

As a parent/guardian, I fully recognize and understand that there are certain injury risks associated in being in a natural environment such as camp and that there is a risk of being injured in such activities as horseback riding, swimming, other water activities, ropes challenge courses, and other outdoor activities.

In consideration of the privilege of camp attendance, it is expressly agreed that all use of services and facilities shall be undertaken at the participant's sole risk and that Camp Adam Fisher, Inc. shall not be liable for any claims, demands, injuries, damages, or causes of action whatsoever to any camper arising out of or connected with the use of any of the services and facilities of the camp.

Further, Camp Adam Fisher, Inc. or our volunteer staff will not be held liable for loss of personal property of the camper.

*PARENT SIGNATURE* \_\_\_\_\_

*PRINT NAME* \_\_\_\_\_

*DATE* \_\_\_\_\_

*CHILD'S NAME* \_\_\_\_\_

**\* THIS FORM IS FOR CAMPERS & CIT'S  
15 AND OLDER ONLY \***

# PAINTBALL REGISTRATION FORM

This release must be signed by the parent or guardian of the camper before the camper will be scheduled the paintball activity.

I request that my child (named below) participate in Camp Cooper's paintball activity and I hereby agree as follows:

I fully understand and acknowledge that: (a) risks and dangers exist in my child's participation in paintball activities and my child's use of paintball equipment; (b) my child's participation in such activities and/or use of such equipment may result in injury or damage to personal property including the potential for permanent disability and death; (c) these risks and dangers may be caused by the paintball activity operator, camp staff members or other participants, or by accidents, or by the forces of nature or other causes.

Risks and dangers may arise from foreseeable or unforeseeable causes including, but not limited to, selection of trail or uneven terrain on the playing field, weather conditions, injuries and/or welts or bruises caused by the paintballs, and such other risks, hazards and dangers that are integral to recreational activities that take place in a wilderness, outdoor or recreational environment; and (d) I hereby accept and assume these risks and dangers.

I have been advised that my child must wear approved protective eye goggles that will be provided by Camp Cooper. **No other padding, gloves or clothing is provided. Campers are required to wear long pants and long sleeve shirts when participating in the activity.** I also understand and agree that Camp Cooper will not be held responsible for damages to clothing or personal belongings. (Paintballs are water soluble, biodegradable, and non-toxic.) I affirm that my child will abide by the rules and regulations presented during the paintball activity orientation.

My child is in good health. I understand that strenuous physical exertion may be required and my child has no known physical disabilities or health problems which will present any risk to his/her participation in the activities.

I have read the above and by signing it agree. It is my intention to grant permission for my child to participate in the paintball activity provided by Camp Cooper, and to assume and accept all risks associated there with.

Camper's Name: \_\_\_\_\_

Age: \_\_\_\_\_  
(must be 15 or older)

Camper's Signature: \_\_\_\_\_

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date



Mail this form to the address below by April 23, 2010

Camp Adam Fisher
P.O. Box 5226
Columbia, SC 29250

CAMP DATES: June 6 – June 12, 2010

Health History and Examination Form

\*\* Attach a copy of the front and back of your insurance card (including Medicaid) and a copy of the participant's Immunization Record. The Immunization can be obtained from your doctor or school.

Name Last First Middle DOB Age

Home Address Street Address City State Zip

Social Security Number Gender Male Female

Custodial Parent/Guardian Phone

Home Address (If different from above) Street Address City State Zip

Business Address Street Address City State Zip Phone

Second parent/guardian or emergency contact:

Address Street Address City State Zip Phone

Business Address Street Address City State Zip Phone

If not available in an emergency, notify:

Name

Relationship Phone

Address

Street Address City State Zip

IMPORTANT – This box must be complete for attendance.

Parent/Guardian Authorization: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/ guardian or adult camper/staff

Printed name Date

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staff Date

## Health History

The following information must be filled in by the parent/guardian or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon the participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

**ALLERGIES** List all known.

Describe reactions and management of reaction.

Medication Allergies:

_____	_____
_____	_____

Food Allergies:

_____	_____
_____	_____

Other allergies (list) include insect stings, hayfever, animal dander

_____	_____
_____	_____

## MEDICATIONS

Please list all medications including medications for diabetes as well as for other conditions. **Insulin will be provided** but you will need to bring a one week supply of other medications. Keep medications in the original packaging or bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.

- This person takes NO medications on a routine basis

### DIABETES REGIMEN:

- Injections: Type of Insulin, Dose and schedule

_____
_____

- Insulin Pump: Type of pump, Type of insulin, Basal rates, and Carb ratio:

_____
_____
_____

- Diabetes Medications: Name, Dose and Frequency:

_____
_____

### OTHER MEDICATIONS:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

**General Questions** (Explain Yes answers below)

Has/does the participant:

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
1. Had any recent injury, illness or infectious disease ?	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized ?	<input type="checkbox"/>	<input type="checkbox"/>	17. Every had problems with joints?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery ?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthopedic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches ?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
6. Every had a head injury ?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	21. Had mononucleosis in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses or contacts?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had problems with diarrhea or constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	23. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	24. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. Have a history of bed wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			

**Explain any "yes" answers, noting the number of the questions.**

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**Please let us know if your child has had frequent or severe hypoglycemia (low blood sugars) in the past 6 months. Please describe frequency, severity and treatment.**

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**Please describe any dietary restrictions.**

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**Please tell us what physical activities your child participates in at home and how often. Please include any restrictions on camp activities for health reasons.**

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Name of Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_

Name of Family Dentist/Orthodontist: \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_

# Health Care Recommendations by Licensed Medical Personnel

Camper Name \_\_\_\_\_

\*Please note that the physical exam has to have been within the last 24 months. **However, this form needs to be completed yearly.**

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ BMI \_\_\_\_\_ HGBA1C \_\_\_\_\_

**In my opinion, the above applicant  is  is not able to participate in an active camp program.**

The applicant is under the care of a physician for the following conditions:

\_\_\_\_\_  
\_\_\_\_\_

## Recommendations and Restrictions at Camp

Treatment to be continued at camp:

\_\_\_\_\_  
\_\_\_\_\_

Medications to be administered at camp (name, dosage, and frequency):

\_\_\_\_\_  
\_\_\_\_\_

Any medically-prescribed meal plan or dietary restrictions:

\_\_\_\_\_  
\_\_\_\_\_

Known Allergies:

\_\_\_\_\_  
\_\_\_\_\_

Description of any limitation on camp activities for health reasons (ie morbid obesity) or any additional information for the health care staff at camp. Please include any information regarding behavioral health.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature of Licensed Medical Personnel** \_\_\_\_\_

Printed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_

## Screening Record

Date Screened \_\_\_\_\_ Time \_\_\_\_\_

Meds Received \_\_\_\_\_

Updates to Health History noted  Yes  No

Current health needs identified \_\_\_\_\_

\_\_\_\_\_

Observational Notes \_\_\_\_\_

\_\_\_\_\_

Screened by \_\_\_\_\_