Florida Diabetes Camp
2015 Summer Camp Sessions

- *Tallahassee Camp* is at Centenary Camp in Quincy, West of Tallahassee
- *Adventure (Cycling) Camp* will begin in North Central Florida (Please Call for Exact Location)
- *Fun Sports Camp* and *Pee Wee Camp* are at Rotary's Camp Florida in Brandon, East of Tampa
- *Winona Sessions 1 and 2* are held at YMCA Camp Winona in DeLeon Springs, near Daytona Beach

Please Note: Adventure and Sports Camps fill-up quickly, please submit these applications as soon as possible

Financial Assistance is Available for All FCCYD Summer Camp Programs

Camp Session	Camp Dates	Cost	Application Deadline
Pee-Wee (ages 6-8)	Sunday, June 14 to Friday, June 19	$500	Friday, June 5, 2015
Tallahassee (ages 7-11)	Tuesday, June 23 to Saturday, June 27	$450	Tuesday, June 16, 1015
Winona I (ages 12-14)	Sunday, July 19 to Sunday, Sunday, July 26	$525	Friday, July 10, 2015
Winona II (ages 9-12)	Saturday, August 1 to Saturday, August 8	$525	Friday, July 24, 2015
Fun Sports Camp (ages 15-18)	Sunday, June 7 to Friday June 12	$575	Friday, May 22, 2015
Adventure Camp (ages 15-18)	Monday, June 22 to Saturday, June 27	$575	Friday June 12, 2015

No child is denied attendance due to financial circumstances. Please call (352) 334-1470 for more information.

ELIGIBILITY, NOTIFICATION & ACCEPTANCE

- All children with type 1 diabetes, includes youngsters who are not yet able to give their insulin independently, are eligible to attend.
- The goal of camp is to make campers more independent in their diabetes care, and age appropriate education will be provided.
- All applications must be signed and witnessed.
- Information and acceptance packets, including directions to camp, will be sent to you two weeks prior to your camp session**.** Please indicate on Page 6 if you would like to receive your acceptance packet via email or U.S. mail.

Applications received after the deadline will be accepted at the discretion of the directors. If your application is not accepted, your deposit will be returned.

SIGNATURES

Please note that your signature, the signature of your camper, and the signature of a witness are needed at the bottom of Page 2 (Witnesses may be anyone over the age of 18.)

PAYMENT, CANCELLATION AND REFUND POLICY

A non-refundable $25.00 deposit for camp programs is required with application (unless other prior arrangements have been made with the camp office). The deposit applies toward camp fees. Cancellations more than 30 calendar days in advance receive full refund (minus deposit); less than 30 days, but more than 10 days, 50 % refund; less than 10 days, but more than 24 hours 25 % refund.
NO SHOW WITHOUT 24 HOURS NOTIFICATION, NO REFUND OR CREDIT TOWARDS OTHER PROGRAMS.

Mailing Address for Applications and Business Correspondence

Florida Diabetes Camp
PO Box 14136
Gainesville, FL 32604

This is our office mailing address. Please DO NOT send mail to campers at this address.
Your child's camp mailing address will be sent to you with the acceptance packet.

CONTACT

Frank Diamond, MD, President
Gary Cornwell, Executive Director
Chris Stakely, Financial Aid Director
Email: fccyd@floridadiabetescamp.org

Janet Silverstein, MD, Medical Director
Phone (352) 334-1321
Phone (352) 334-1470
Fax (352) 334-1326

http://www.floridadiabetescamp.org

2015 Florida Diabetes Camp

Summer Camp Application for session (please check one):

Tallahassee Camp (Ages 7-11) _____ **Pee-Wee Camp (Ages 6-8) _____**
Winona Session 1 (Ages 12-14) _____ **Winona Session 2 (Ages 9-12) _____**
Fun Sports Camp (Ages 15-18) _____ **Adventure Camp (Ages 15-18) _____**

(If applying for multiple sessions please indicate first choice)

CAMPER INFORMATION:

Name_____ Nickname _____
Last First Middle Initial

Address _____

City _____ State _____ Zip _____ County _____

Date of Birth ___/___/___ Age at Camp ____ Date Diagnosed (month/year):_____/_____ Sex_____ Race_____

Grade next year (Fall 2015) ____Type of Class: Gifted ____ Regular Ed.____ Special Ed. (Specify) _____

Camper's Height: _____Camper's Weight: _____ T-shirt Size (Please Circle) **CM CL AS AM AL AXL AXXL**

Has child previously attended a FCCYD summer camp or Weekend Program? Yes____ No____

PARENT/GUARDIAN INFORMATION:

Name of Parent/Guardian # 1 at same address as the Camper _____

Relationship to Camper_____ Legal authority for child? Yes_____ No_____

Home Phone (___) _____Work Phone (___)_____ Cell Phone (___)_____

E-mail address (print clearly) _____

Occupation _____ Company Name_____

PARENT/GUARDIAN INFORMATION:

Name of Parent/Guardian # 2 at same address as the Camper _____

Relationship to Camper_____ Legal authority for child? Yes_____ No_____

Home Phone (___) _____Work Phone (___) _____ Cell Phone (___) _____

E-mail address (print clearly) _____

Occupation _____ Company Name_____

IF APPLICABLE, CONTACT INFORMATION FOR PARENT/GUARDIAN <u>NOT</u> LIVING WITH CAMPER:

Name of Parent/Guardian _____

Relationship to Camper_____ Legal authority for child? Yes_____ No_____

Home Phone (___)_____Work Phone (___)_____ Cell Phone (___)_____

E-mail address (print clearly) _____

Occupation _____ Company Name_____

NAMES AND AGES OF SIBLINGS OR OTHERS LIVING IN THE SAME HOUSEHOLD AS THE CAMPER:

_____

_____

In the event of an emergency, please supply the name of an additional person we can contact in case we are unable to reach the Primary Parent/Guardian(s). This individual should not live in the same household as the camper.

Name _____ Relationship to camper _____

Phone (_____) _____ Cell Phone (_____) _____

Name of Endocrinologist: _____ Phone (_____) _____

This Page to be Completed and Signed by Parent/Guardian, Camper, and Witness:

THE FOLLOWING MUST BE COMPLETED FOR ATTENDANCE

This page must be completed and signed by a parent or legal guardian, the camper AND a witness and returned with the application. Unless this page is signed, witnessed, and dated, it will be returned to you and your child's spot will not be held until it is completed and returned to the camp office.

MEDICAL TREATMENT RELEASE

(Name of camper) _____ has permission to engage in all prescribed camp activities.

I hereby give permission for the camp personnel:

a) To provide ongoing medical care, including regular blood and urine tests for sugar and ketones; making insulin dose adjustments; and pump changes as necessary and as described in the pump protocol section on page 6 of this application.
b) To select all medical personnel and order x-rays or any routine tests or treatment for the person listed above.
c) In an emergency, the camp medical director may seek to transport, hospitalize, secure treatment for, and order injections, anesthesia, and/or surgery for medical or dental problems for the person named above. I understand that every effort will be made to notify me or the emergency contact listed on page 1..
d) To share my child's medical information and camp records with his/her referring physicians, CMS coordinator (if applicable), emergency personnel and other care providers as deemed necessary by FCCYD staff.
e) "I give my permission to the Florida Camp for Children and Youth with Diabetes, Inc. and the Directors to transport and admit my child to a hospital in the event that medical attention is necessary. This may include tests, x-rays, anesthesia, and/or surgery for medical or dental problems for the camper named above. I understand that the camp will notify me of any emergency as soon as possible. I understand that the Florida Camp for Children and Youth with Diabetes is not responsible for injury that may result from accidents, illnesses, or other causes."

ACCURACY OF INFORMATION

To the best of my knowledge, all information contained in this application is correct.

RELEASE OF RECORDS

I hereby authorize my child's physicians, counselors, case workers, and school personnel to release/share any records and information deemed pertinent to be included in the review of my child's application and participation at camp.

FINANCIAL AID

By applying for financial assistance (See Page 8), I/We give permission to FCCYD, Inc. to use our name and our child's name and likeness when seeking campership assistance specifically for our family.

BEHAVIORAL EXPECTATIONS

We are all coming to camp to have a safe, fun, and enriching experience. To help meet these goals, appropriate behavior is expected of ALL campers in our care. Our expectations include:

a) Following all safety and medical rules.
b) Eating a balanced meal. Reasonable alternatives are provided.
c) Participation in scheduled camp activities.
d) Refraining from the use of abusive language, violence, or other inappropriate behavior.
e) Staying with assigned group or cabin and treating other campers, counselors, and staff with respect.
f) Possession and/or use of tobacco products, alcohol, any illegal substance, weapons, or medication not registered with the camp nurse are prohibited and will result in immediate expulsion and/or prosecution.

If a camper is having difficulty adhering to these expectations, he/she will be counseled and encouraged to modify his/her behavior. If inappropriate activity continues, a camper will be expected to agree to a behavioral contract and ultimately be asked to return home if the inappropriate behavior persists. A child having difficulty adhering to these expectations risks losing the privilege of returning to camp in the future.

FCCYD reserves the right not to accept applications from youngsters who after repeated attendance at camp do not meet these behavioral expectations and/or have not received counseling as recommended by FCCYD staff.

I have read this with/to my child and we understand and agree to all the above releases and conditions.

(If other than biological or adoptive parent(s) please attach legal affidavit with this application)

- **Signature of parent or legal guardian _____ Date _____**
- **Signature of Camper _____ Date _____**
- **Witness (must be witnessed by an adult) _____ Date _____**

All 3 Signatures Required to Process Application

This Page to be Completed and Signed by Your Endocrinologist

(Please take this form with you to your child's next Endocrinology appointment)

CAMP HEALTH HISTORY AND EXAMINATION FORM FOR 2015

Camper's Name _____Session_____

Birthdate_____/_____/____ Date of last exam _____/_____/_____ Most recent HgbA1C _____ Date___/____/___

Date Diabetes Diagnosed _____ Height _____ Weight _____ Blood pressure_____/_____

INSULIN DELIVERY SYSTEM USED AT HOME: Injections Pump: Brand/Model: _____

Insulin Type:

Humalog Humulin NPH Humulin Regular Humalog Mix 75/25 Humulin 70/30 Lantus (Glargine)

Novolog Novolin NPH Novolin Regular Novolog Mix 70/30 Novolin 70/30 Levemir (Detemir) Apidra

Other **Medical Conditions** (e.g. asthma, heart murmur, etc.): _____

_____

Date and nature of any **operations, injuries, or non-diabetes related hospitalizations** in the past 12 months:

_____

History of **Diabetes Related Visits to the ER or Hospitalizations**? (Yes/No/Unknown)? _____

If yes, please list dates and reasons: _____

_____

History of **hypoglycemic seizures** (Yes/No/Unknown)? _____

If yes, what time of day do seizures typically occur: _____

Reason for hypoglycemic seizure: _____

Has child required **psychological counseling** in the past 12 months: (Yes/No/Unknown)? _____

If yes, date and nature of care: _____

Is child taking **psychotropic medications**? (Yes/No/Unknown)?_____ If yes, which ones?_____

Is child currently being treated by a **counselor/psychiatrist/psychologist/therapist:** (Yes/No/Unknown)? _____

If yes, date and nature of care: _____

Has child ever been **hospitalized for psychological issues** (Yes/No/Unknown)? _____

If yes, date and reason for hospitalizations: _____

Treatment other than diabetes management to be continued at camp: _____

_____

CURRENT MEDICATIONS:

RX: _____ Dose: _____ Reason: _____

RX: _____ Dose: _____ Reason: _____

RX: _____ Dose: _____ Reason: _____

Licensed physician full name (please print**)** _____

Physician's/Nurse's signature _____ Date form completed_____

Please contact our office for additional information regarding this child's ability to attend Camp YES / NO

If yes, best contact for additional information _____?

Best number for office contact: (____)_____ Or address if email is preferred: _____

(Doctors may fax completed forms to (352) 334-1326 or email them to gtc@peds.ufl.edu)

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This Page to be Completed by Parent/Guardian:

CAMPER HEALTH HISTORY

Camper Name_____ Camp Session _____

Give approximate dates for the following illnesses:

	Ear Infections		Dehydration/vomiting with ketones
	Heart defect/disease		Chicken Pox
	Seizures		Asthma
	Bleeding/clotting disorders		Poison Ivy, etc.
	High blood pressure		Other (Please Note):

Date of last physical examination_____ Physician's name _____

Other **Medical Conditions**: _____

Dates and nature of any **surgeries or injuries**_____

_____

Disability or **chronic or recurring illness**_____

How many **Diabetes Related Visits to the ER** in the last 12 months:_____ List dates and reason:
Hypoglycemia:_____ DKA:_____ Other: _____

_____

How many **Diabetes Related Hospitalizations** in the last 12 months:_____ List dates and reason:
Hypoglycemia:_____DKA:_____Other: _____

_____

Any **hypoglycemic seizures** in the past 12 months :(Y/N)? _____
If yes, what time of day did seizure occur: _____
Reason for hypoglycemic seizure: _____

Does your child have any **behavioral/psychological problems** of which we should be aware or that need to be discussed with camp personnel? _____

Has your child seen a **counselor/psychologist/psychiatrist/therapist**? No _____Yes _____Dates_____
Reason _____

Has your child ever been **hospitalized for behavioral or psychiatric care**? _____
If so when and why?_____

How many days of school did your child miss this year due to **behavioral problems**_____
or **diabetes** _____ Please explain _____

Allergies/Symptoms_____
Uses **EpiPen** for Allergic Reactions? (Y/N)? _____ If yes, please bring EpiPen to camp

Dietary Restrictions: Celiac_____ Vegan_____ Vegetarian_____ Kosher_____
Lactose Intolerant_____ Other (Please Specify): _____

CURRENT MEDICATIONS: ***Please bring all medication with you and give to the camp nurse at Registration!***
RX: _____ Dose: _____ Reason: _____
RX: _____ Dose: _____ Reason: _____
RX: _____ Dose: _____ Reason: _____

If your child is on medication for **ADHD** during the school year, medication must be continued at camp

Has your daughter started her **period?** Yes _____ No_____ When_____
If your daughter has not started her period, has she been told about menstruation? _____

There will be NO special concessions for those who have their period during the camp sessions. Campers are required to participate in all activities, including swimming, even if menstruating. Campers should bring their own sanitary supplies

This Page to be Completed by Parent/Guardian:

SCHOOL, REPORT CARD, INSURANCE, IMMUNIZATION, ACCEPTANCE & TRANSPORTATION

Child's Name _____

Session Attending _____

Age at time of photo _____

Name of School _____

Current Grade_____

(Or most recently completed grade if applying for camp after the end of the school year)

Home Schooled_____

Please Staple or Tape **Photo Here**

Do Not Glue (Thanks)

(Please write name and age at time of photo on the back)

School Attendance: Days missed (absent) during the school year_____

Reason for absence _____

*PLEASE ENCLOSE A COPY OF THE MOST RECENT **REPORT CARD** AVAILABLE.*
REQUIRED FOR ACCEPTANCE.

INSURANCE: Do you carry medical/hospital insurance? Yes____ No____

Name of Carrier _____Policy/group Number_____

Telephone Number of insurance company _____ Address _____

City _____ State _____ Zip _____ County _____

Please send a photocopy of your insurance card for our records including Medicaid or CMS Network card.

IMMUNIZATIONS

VACCINES	YEAR OF BASIC IMMUNIZATION	YEAR OF LAST BOOSTER
DPT (Diphtheria, Pertussis/Whooping Cough, Tetanus) TD* (Tetanus, Diphtheria) or tetanus toxoid		*
MMR (Measles, Mump, Rubella)		
Polio		
Hepatitis B		
Chicken Pox		

You may substitute a school or State of Florida immunization form**.**

If you are a returning camper and have previously submitted the record, you only need to list updates and boosters.

If your child has not received the additional MMR **booster** after the original one at age 12 - 18 months, please consult your doctor.

FCCYD Medical Staff strongly recommends that ALL campers be immunized against Hepatitis B.

***Tetanus immunization must be up to date. Please consult your doctor.**

TRANSPORTATION INFORMATION

My child _____ will be brought to camp by _____.

He/she will be picked up by _____.

Each camper must proceed through CHECK-IN/ INTAKE upon arrival at camp with a parent or other responsible adult who can provide medical and other data to the medical director and counselors.

ACCEPTANCE

In order to save resources, FCCYD would like to send your acceptance packet via email unless you indicate otherwise.

Please select your preferred method for communication: **Mail** _____ **Email** _____

If email, what is your preferred address: _____

Cabin Buddy (Every effort will be made to place friends together, but there are no guarantees):

_____

This Page to be Completed by Parent/Guardian:

Diabetes Information

(You will have an opportunity to update this information at Medical Intake during Registration)

Campers Name: _____ Camp Session: _____

Insulin Delivery System Used at Home: Injections Pump

Insulin Type:

Humalog Humulin NPH Humulin Regular Humalog Mix 75/25 Humulin 70/30 Lantus (Glargine)

Novolog Novolin NPH Novolin Regular Novolog Mix 70/30 Novolin 70/30 Levemir (Detemir) Apidra

Insulin Dose (Injections):

AM_____Lunch_____PM_____Bedtime_____

(Please indicate dose and type of insulin **example**: 12N/3H for 12 units of NPH and 3 units of Humalog)

Insulin : Carbohydrate ratio: ***(example: 0.5: 10 or 1:8 or 1:15 etc.)***

AM_____Lunch_____PM_____Bedtime_____

Correction Factor/Sliding Scale**:** (example: 1 for 50 > 150 or 1 for 25 > 125 etc.)

AM_____Lunch_____PM_____Bedtime_____

Pumps:

Pump Brand/Model: _____ Type of Infusion set:_____

Basal rates:

Time:	Rate:
12am	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Target Blood Glucose Range:

Time:	Setting:
_____	_____
_____	_____
_____	_____
_____	_____

Insulin Sensitivity Factor (ISF):

Time:	ISF:
_____	_____
_____	_____
_____	_____
_____	_____

Insulin on Board (IOB)/Active Insulin/
Duration of Insulin Action: **# of hours: _____**

Insulin to Carbohydrate Ratios (I:C):

Time:	I:C:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

The Florida Diabetes Camp provides an extremely active program in which a large percentage of daily activities involve water sports. Because of this, insulin pump use during the camp session can be challenging and require extra effort. This is especially true at the Winona Sessions where campers will be going in the lake several times a day. If campers choose to wear a pump, the following protocol is in effect.

1. The pump may be discontinued if the camper is having frequent hypoglycemia, site infections, etc. If this occurs, insulin will be administered via injections for the remainder of the camp session. This decision rests solely with the FCCYD Medical Director and/or camp physician.
2. The family will need to bring **all** pump related supplies. Insertion sites may need to be changed as often as once per day because of increased activity in the water and at land sports. Bring one set for each day. The family understands that FCCYD is NOT responsible for pump breakage or loss. Family should check the pump batteries before camp and send an extra set of batteries.
3. Camper/Parent/Guardian agrees to the guidelines as described in this policy and understands that the Medical Director and physicians of the Florida Diabetes Camp will be making the decisions regarding our child's pump usage while at camp.
4. Pump site should be changed in the morning prior to camper's arrival at camp.

This Page to be Completed by Parent/Guardian:

PAYMENT OPTIONS AND FINANCIAL AID

Costs: Sports Camp: $575.00; Adventure Camp: $575.00; PeeWee Camp: $500.00; Tallahassee Camp: $450.00; Winona Sessions: $525.00

Camper's Name _____Session_____

1._____FAMILY IS ASSUMING RESPONSIBILITY FOR PAYMENT OF ALL CAMP FEES.

_____ A. Full payment enclosed (cost in front) $ _____ By check/money order or Charge Card below

_____ B. Please Contact the Financial Aid Director at (352) 334-1470 to arrange **Payment Plans** and dates to run credit/debit cards

Debit or Credit (please circle - Visa/MasterCard/American Express/Discover Card)

Card Number_____-_____-_____-_____ Exp. Date ____/____ Security Code # _____

Card Holder's Name_____

Cardholder's Billing Address_____City/State _____Zip_____

Signature_____

2._____SPONSORSHIPS AND FINANCIAL AID: This section must be filled out completely

FCCYD policy states that all eligible children can attend regardless of amount of fee family can pay. However, FCCYD is a private not-for-profit organization and is not affiliated with any national diabetes charity. Therefore, a limited amount of scholarship money is available. We ask that all families pay as much of the fee as they can so that we may assist as many campers as possible. A sliding scale is used to determine scholarship awards.

A. **A $25.00 deposit** must be sent with <u>all</u> applications. Please enclose Check/Money Order or fill out Debit/Credit Card Information above and date to run card.

B. Based on your current income, **total amount** you can pay (including deposit) $_____

C. I already have a **sponsor** (name)_____ They have pledged: $_____

D. **Total Household Income**

	Place of Employment	Position	Monthly Income before taxes
Mother	_____	_____	_____
Father	_____	_____	_____
Step-parent	_____	_____	_____
Step-parent	_____	_____	_____
Grandparent	_____	_____	_____

E **Other Sources of Income**: Child Support: $ _____ monthly

Disability, social security, retirement, unemployment: $ _____ monthly

F. **Other required information:**

Is camper in **foster** care? YES NO Caseworker Name & phone number: _____

Is household eligible for **food stamps**? YES NO

Is camper eligible for **reduced or free school lunch**? YES NO

Is camper eligible for **Medicaid** (Medicaid does NOT pay for camp)? YES NO

Is camper seen by **Children's Medical Services** (CMS)? YES NO

CMS Care Coordinator Name: _____Phone _____

You must submit a copy of your Medicaid or CMS Network Card if applicable

G. Is there a special financial situation that may require our consideration?

_____

_____

_____

Please apply as early as possible for financial aid and scholarships as resources are limited. Families are encouraged to contact service clubs, business, churches, and organizations such as Kiwanis, Rotary, Lions, Eagles, Veteran's Groups, etc in your area for sponsorships. The American Diabebetes Association (ADA) also provides a limited number of scholarships for children to attend camp. CMS (Children's Medical Services) will no longer pay camp fees and Medicaid does not pay for camp either. Consequently, all CMS and Medicaid clients must apply for financial aid through the Florida Diabetes Camp. Please complete the above application in full and send it along with your completed application and a $25.00 deposit to the camp office. The goal of our financial aid director is to help as many deserving families as possible attend camp.

GENERAL PACKING SUGGESTIONS FOR 2015 CAMPS

(Packing list for your child's specific camp session will be sent prior to the start of camp)

Cell Phones And Other Devices That Allow Texting Or Internet Access Are Prohibited At Camp

Do Not Let Your Child Bring Any Items That Would Upset You If They Were Lost or Stolen
FCCYD is not responsible for items lost, stolen, or broken. **Print camper's name on belongings**.
We recommend duffel bags for packing, no trunks or large suitcases, as there is limited storage space

CLOTHING:
____ Shorts (1 pair/day)
____ 1 Pair Long pants or jeans
____ T-Shirts (1 or 2 per day)
____ Socks (1 or 2 pair/day)
____ 2 pair shoes (sneakers are fine)
____ 1 pair of flip-flops
____ Underwear (2 pair/day)
____ Night clothes (extra for bedwetters)
____ 2 or more bathing suits if possible (Esp. Winona)

OTHER ITEMS:
____ Rain coat or poncho
____ Dirty laundry bag (marked with child's name)
____ Flashlight and batteries
____ Sunscreen (SPF 15 or higher)
____ Sun hat/ visor
____ Insect repellant lotion
____ Disposable camera **(put camper's name on it)**
____ Light Sweatshirt

LINENS and TOILETRIES:
____ 2 sets of sheets (single bed flat and fitted)
____ Plastic sheet or mattress cover for bedwetters
____ Pillow and 2 pillowcases
____ Light Blanket/sleeping bag optional
____ 4-6 towels/washcloths (extra towels are important)
____ Toothpaste and toothbrush
____ Soap (liquid soap or body wash not bar soap)
____ Comb/hair brush
____ Shampoo (tear free for little ones)
____ Sanitary Napkins or Tampons

MEDICATIONS: Campers on insulin pumps need to bring supplies for the pump (one infusion site per day AND batteries for pump) All insulin will be provided. For campers taking injections, all supplies will be provided. Meters and strips for ALL campers will be supplied. If your child uses an EpiPen, please bring that to camp with your child's name clearly marked on the pen. All other prescription medications must be brought with camper.

DO NOT BRING:

CELL PHONES, THEY WILL BE CONFISCATED AND RETURNED AFTER CAMP

Any items considered dangerous (Knives, guns, weapons, or fireworks)
Alcohol, tobacco products, or any controlled substances or drugs
Food of any kind (gum, candy, etc. even if sugar free)
Large footlockers or trunks (there is no place to store them)
Electronic games, CD players, tape players, radios, cell phones, iPods, pagers or two-way radios
Money, jewelry, or expensive articles.

Have you:

1) Completed all information on Page 1 including **Emergency Contact** name, address, and phone number. Emergency contact should be someone who does not live in the same household as the camper.
2) Completed Page 2 including signature of Parent/Guardian, camper, and witness
3) Completed Pages 5 and 6 including Immunization Records. Returning campers need to provide us with updates and boosters only. Please make sure you provide us with a current photo, a copy of the most recent available report card, and a copy of your insurance card.
4) Completed all diabetes related information on Page 7
5) Completed Page 8 with your payment plan.
6) Enclosed a minimum deposit of $25.00 is required in order for us to process the application whether or not you are applying for financial aid.
7) If you are applying for financial aid please complete Section 2 on page 8 in full. The more information you provide us the more helpful it will be for us to process your request.
   Note: Even if you are a CMS or Medicaid client, this information is required for all scholarship requests
8) Camps, especially Sports and Adventure, fill up quickly so please get your application in before the deadline
9) **Please make sure that Page 2 is signed by the Camper, Parent/Legal guardian, and a Witness. Applications cannot be processed without this completed page.**

Questions:

Call Gary at (352) 334-1321 or Chris at (352) 334-1470. Email: fccyd@floridadiabetescamp.org