Dear Parents/Guardians,

We are excited that you have chosen The Jack Rua Camp for Children with Diabetes (Camp Jack) this summer. The Diabetes Association, a program of People, Incorporated, has operated its diabetes camp each summer for over 30 years. Diabetes camp is a wonderful learning experience for your child and is an environment that is unlike any other summer camp. We have many fun and exciting activities planned for Camp Jack, all of them designed to help your child, their siblings and friends learn how to live long, healthy, happy lives with or without diabetes.

Please be aware that our camper applications are accepted without regard to ethnicity, race, church denomination or religion, on a space-available basis in the order they are received with payment. Applications received *during* the camp season are subject to space availability.

In addition to registration forms, you will find several colored sheets of paper (if printing from an electronic source, color coding will not apply. *Please print 1 sided*). They include:

- (1) Photo Release Form: Light pink paper to be completed and returned.
- (1) Fieldtrip Form: Bright yellow/gold paper to be completed and returned.
- (1) Payment Chart: Light purple paper to be used as a reference for you to determine payment calculations.
- (1) Financial Assistance: Green paper to be completed and returned with all applicable documents attached (if assistance is needed).
- (1) Credit Card Payment Form: White paper to be completed and returned with registration (if applicable).

Also included is the Camp Jack Parent/Guardian Handbook. This document will help you prepare your child/ren for their camp experience. It includes an overview of the diabetes camp, a typical daily schedule, arrival and departure policies, camp rules and policies (including rules for the bus), emergency policies, health information and frequently asked questions.

This is a very exciting time for your child and we strive to make their experience enjoyable and memorable. We are honored to be able to share in this special time and look forward to caring for your child this summer at Camp Jack!

Sincerely,

Tina Nogueira

Tina Nogueira, Camp Coordinator

PS- Don't forget to visit us for Open House
on Sunday, June 22nd 2014 ~ 11am-2pm
Camp Jack, 90 Pond St. Rehoboth, MA
Refreshments will be provided

To help you complete your **Camp Jack Registration Packet**, please use the following **checklist** to ensure that all documents have been filled out completely and attached as needed. All forms are mandatory and incomplete forms are subject to forfeiture of selected camp weeks.

- ☐ Acknowledgment of Policies and Procedures (p.2)
- ☐ Camp Waivers (p.3)
- ☐ Parent/Guardian and Emergency Contact Information (p.4)
- ☐ Authorized Person(s) Pick up List (p.5)
- ☐ Camper Information, Camp Weeks and Transportation Information (p.6)
- ☐ Diabetes Health and Dietary Information (*if applicable*) (p.7)
- ☐ Camper Health History Form 1 (p.8-11)
- ☐ Camper Health Recommendations Form 2 (p.12)
- ☐ Copy of Physical Examination
- ☐ Copy of Diabetic Orders (if applicable)

Registration must be submitted no later than June 23, 2014 for a July 7th start date. Camp Jack's health care consultant requires 2 weeks for review of health information. If signing up once camp has already begun, registration must be submitted no later than 10 business days before starting camp.

Registration should be returned to:

Tina Nogueira
People, Incorporated
4 South Main St.
Fall River, MA 02721

Please make checks payable to ***Diabetes Association*** *and* include **CHILD'S NAME** and **WEEK NUMBER** on memo line.

Example

John Doe
222 Somewhere St.
Fall River, MA 02721

______________ Date

Pay to the
Order of Diabetes Association ______________ $ [ ]

____ Dollars

Memo: CHILD'S NAME and WEEK NUMBER ______________________

Credit Card payment form (See attached)

Fill out 1 form per FAMILY

Acknowledgement of Policies and Procedures for the Jack Rua Camp for Children with Diabetes

Registration packets will not be processed if this acknowledgement is not signed by the parent/guardian of the camper.

By submitting this registration packet for the **Camp Jack 2014 Camp Season**, I, ________________________________, acknowledge that I have read, understand and agree to the policies and procedures found in the Camp Jack Parent/Guardian Handbook. I also understand that the Diabetes Association, a program of People, Incorporated, operates the Jack Rua Camp for Children with Diabetes in accordance with the Massachusetts Department of Health's Day Camp Policies and any violation of these policies will result in disciplinary action for my camper(s) as noted in the Discipline Policy sections of the handbook. Lastly, I understand that available camp slots are filled first with children with diabetes, their siblings and friends. If there are open camp slots they will be assigned to children who are not living with diabetes on a first come, first served basis.

Child(ren) attending camp:

Camper #1: ____________________________________

Camper #2: ____________________________________

Camper #3: ____________________________________

Camper #4: ____________________________________

____

Print Name, Parent/Guardian

____ Date: ____________

Signature, Parent/Guardian

Fill out 1 form per FAMILY

Camp Waivers **Registrations will not be processed until this form is completed and turned in to the Diabetes Association office.**	**Initial in Boxes Below**
I give my camper permission to participate in all camp activities except where noted. I will provide a note to the Camp Coordinator if this situation changes for any reason.	
I give my permission for my camper's belongings to be examined (with camper present) if necessary when the health and well-being or safety of the camper(s) requires it. I understand that I will be notified if such a situation occurs.	
I give my camper permission to ride in the camp-designated vehicles for all off-site trips, including van, bus or emergency medical transportation if needed.	
I give my permission for the camp staff to use sunscreen and other protective topical lotions on my camper as necessary.	
I give my camper permission to participate in off-site activities led by staff.	
I give the Camp Nurse permission to share pertinent medical information with the camp staff.	
I give the Camp Nurse permission use an EPI Pen or Glucagon in an emergency.	
I give the Camp Nurse permission to treat, dispense medication and seek emergency treatment.	
I give the Camp Nurse permission to contact my child's doctor and discuss my child's medical information with them.	
I understand that parents/guardians have the right to review the following policies and grievances upon request. Staff background check, health care and discipline policies included.	
I understand that my child is required to have insurance, as they are not covered under the insurance of Camp Jack. I have provided my child's insurance information on the Camper Health History form.	
I understand that the Diabetes Association, a program of People, Incorporated, reserves the right to dismiss my camper from any of its programs for any behavior deemed inappropriate according to its Rules, Policies, and Procedures. Dismissed participants ***will not be entitled to a refund*** of program fees.	

I object to the following and ***will not sign*** off on: ____

____

Child/ren attending camp:

Camper #1: ______________________________ Camper #2: ______________________________

Camper #3: ______________________________ Camper #4: ______________________________

______________________________ ______________________________

Print Name, Parent/Guardian **Signature, Parent/Guardian**

Date: ________________

Fill out 1 form per FAMILY

Parent/Guardian and Emergency Contact Information

Camper #1: ______________________ Camper #2: ______________________

Camper #3: ______________________ Camper #4: ______________________

Parent/Guardian Information		
Last Name	First Name	Middle Initial
Street Address	City	State / Zip Code
Home Phone #	Cell Phone #	Work Phone #
Email Address:		
Alternative Address of Parent/Guardian (if travelling while child is attending camp)		
Alternative Phone number of Parent/Guardian (if travelling while child is attending camp)		

At least one emergency contact required

Emergency Contact Information		
Last Name	First Name	Middle Initial
Relation to Camper		
Home Phone #	Cell Phone #	Work Phone #

Emergency Contact Information		
Last Name	First Name	Middle Initial
Relation to Camper		
Home Phone #	Cell Phone #	Work Phone #

Fill out 1 form per FAMILY

Office Use Only
Bus Stop: _______________
On Site: ________________
Weeks: 1 2 3 4 5 6
Please keep one (1) copy in camper(s) file and one (1) copy on-site or van/bus at all times.

Authorized Person(s) Pick Up List for *Family*

Only the Person(s) listed will be authorized to pick up your camper(s)

Camper (1) Name:
Camper (2) Name:
Camper (3) Name:
Camper (4) Name:

Authorized Person(s)

1. Last Name	First Name	Middle Initial
Emergency Contact Phone No.	Relation to Camper:	
2. Last Name	First Name	Middle Initial
Emergency Contact Phone No.	Relation to Camper:	
3. Last Name	First Name	Middle Initial
Emergency Contact Phone No.	Relation to Camper:	
4. Last Name	First Name	Middle Initial
Emergency Contact Phone No.	Relation to Camper:	

Parents/Guardians/Authorized Person(s) must physically sign-in their camper with staff each morning. Campers riding the bus will be noted on the bus attendance by staff. This ensures the child's safety and also allows the staff to pass on any information that the parent/guardian/authorized person may need to know regarding the day's events.

Camper(s) will **only** be released to persons identified on the above Authorized Person(s) form.
This form will remain in the bus binder or on camp premises at all times.

If an unauthorized person tries to pick up a camper, phone calls will be placed to the parents/guardians to inform them of the situation.

If a parent/guardian cannot be reached, **the child will not be released**. It is the policy of Camp Jack, as written in the parent handbook, that children who are not picked up will be dropped off at the local Police Department until the parent/guardian may pick them up.

Fill out 1 form per CAMPER

Jack Rua Camp for Children with Diabetes

2014 Registration Form

Please attach a current photo of your child

This photo is used strictly for safety reasons and will significantly reduce the time it takes to identify a child in the event of an emergency

Camper Information		
Last Name	First Name	Middle Initial
Street Address		
City	State	Zip Code
School Attending	Birthday	Age as of August 16th 2014
New or Returning Camper	If New, How or by Whom did You Hear About Camp Jack?	

Please Check Off the Week(s) Your Camper will Attend				
Week 1: July 7 – 11			**Week 2:** July 14 - 18	
Week 3: July 21 - 25			**Week 4:** July 28 - August 1	
Week 5: August 4 - 8			**Week 6:** August 11 - 15	

Transportation Information**

Select **(by circling)** the location where your camper will be picked up and dropped off

City/Town	Van/Bus Location	Pick-up	Drop-off
Dartmouth	Southcoast Medical Center – 300 Faunce Corner Rd.	7:45am	4:45pm
Fall River	Stop & Shop – 501 Rodman St. ***(Location of Fall River stop, subject to change. You will be contacted if any changes occur)***	8:10am	4:25pm
Swansea	1st Congregational Church – 1113 GAR Highway	8:25am	4:05pm
I will drop off and pick up my camper at Camp Jack, 90 Pond St. Rehoboth		8:45am (no earlier, please)	3:45pm

The safetey of our campers is our **first priority. Please review all policies and procedures reguarding Arrival and Departure and Transportation. Failure to comply with bus rules at all times will result in the loss of bus priveleges.

Fill out 1 form per CAMPER

*****Please attach a copy of your child's Diabetic Orders.**

Diabetes Health Information

Please disregard if your camper does not have diabetes or special dietary needs.

Name of Camper			Date of Diagnosis
Place where Camper Receives Diabetes Care			
Name of Camper's Endocrinologist			Phone Number
Latest HbA1C			Date Taken
Will your camper be taking insulin during camp? If YES, when and in what dose?	**YES**	**NO**	
Does the camper give own injections? If YES, what type of syringe does the camper use?	**YES**	**NO**	
Are supplemental injections of insulin given frequently? If YES, when and why are they given?	**YES**	**NO**	
Pump:			Bolus (units/gm carbs)
Supplement ("sensitivity factor")			
Oral Medication (type/doseage)			Dose(s)/Time(s)

Dietary Information/Allergies

Please provide all information regarding your camper's diet that ***requires special attention***, including carb numbers, food allergies, etc.

What is the most effective way to treat camper's ***hyper***glycemia (highs)?

What is the most effective way to treat camper's ***hypo***glycemia (lows)?

What is the relationship between exercise, diet, insulin and their effects on blood glucose readings?

Fill out 1 form per CAMPER

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Mail this form to the address below by _______ (date)

Dates will attend camp: from _____________ to _____________
Month/Day/Year Month/Day/Year

Camper Name: ____
First Middle Last

☐ Male ☐ Female Birth Date ____________ Age on arrival at camp: ________
Month/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1) ***Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.***
2) ***Send the original, signed FORM 1 to camp by the requested date.***
3) ***Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.***
4) ***After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.***

Camper Home Address: ____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: ______________________ Relationship to Camper: ______________ Preferred Phones: (_____) ______________ (_____) ______________

Email: ______________________

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

Second parent/guardian or other emergency contact:

Name: ______________________ Relationship to Camper: ______________ Preferred Phones: (_____) ______________ (_____) ______________

Email: ______________________

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): ______________________ Relationship to Camper: ______________ Preferred Phones: (_____) ______________ (_____) ______________

Allergies: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet.
☐ This camper has special food needs. ***(Please describe below.)***

Restrictions: ☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. ***(Please describe below.)***

Medical Insurance Information:

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company________________________ Policy Number______________________

Subscriber____________________________ Insurance Company Phone Number (_____) ______________

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian ______________________________ Date: ______________ Relationship to Camper: ______________

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Page 1/4

Camper Name ______ First ______ Middle ______ Last ______ (For Camp Use) Cabin or Group ______ (For Camp Use) Session Code(s): ______

Fill out 1 form per CAMPER

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: ____
First Middle Last

Birth Date: ____________
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis★ (DTaP) or (TdaP)						
Tetanus booster★ (dT) or (TdaP)						
Mumps, measles, rubella★ (MMR)						
Polio★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative	☐ Positive

If your camper has not been fully immunized, please sign the following statement**:** **I understand and accept the risks to my child from not being fully immunized.**

Signature of Custodial Parent/Guardian: ______________________________ Date: __________ Relationship to Camper: ______________

Medication: ☐ This camper will not take any daily medications while attending camp.

☐ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers.* Many states require *original pharmacy containers with labels* which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.**

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:__________		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:__________		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:__________		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

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Fill out 1 form per CAMPER

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: ______________________________
First Middle Last

Birth Date: ____________
Month/Day/Year

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

1. Ever been hospitalized?	☐ Yes	☐ No	11. Had fainting or dizziness?	☐ Yes	☐ No
2. Ever had surgery?	☐ Yes	☐ No	12. Passed out/had chest pain during exercise?	☐ Yes	☐ No
3. Have recurrent/chronic illnesses?	☐ Yes	☐ No	13. Had mononucleosis ("mono") during the past 12 months?	☐ Yes	☐ No
4. Had a recent infectious disease?	☐ Yes	☐ No	14. If female, have problems with periods/menstruation?	☐ Yes	☐ No
5. Had a recent injury?	☐ Yes	☐ No	15. Have problems with falling asleep/sleepwalking?	☐ Yes	☐ No
6. Had asthma/wheezing/shortness of breath?	☐ Yes	☐ No	16. Ever had back/joint problems?	☐ Yes	☐ No
7. Have diabetes?	☐ Yes	☐ No	17. Have a history of bedwetting?	☐ Yes	☐ No
8. Had seizures?	☐ Yes	☐ No	18. Have problems with diarrhea/constipation?	☐ Yes	☐ No
9. Had headaches?	☐ Yes	☐ No	19. Have any skin problems?	☐ Yes	☐ No
10. Wear glasses, contacts, or protective eyewear?	☐ Yes	☐ No	20. Traveled outside the country in the past 9 months?	☐ Yes	☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	☐ Yes	☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?	☐ Yes	☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?	☐ Yes	☐ No
4. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)	☐ Yes	☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): ______________________ Phone: (________) ________________

Name of dentist(s): ______________________ Phone: (________) ________________

Name of orthodontist(s): ______________________ Phone: (________) ________________

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. ***Attach additional information if needed.***

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

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Fill out 1 form per CAMPER

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: ______________________________
First Middle Last

Birth Date: ____________
Month/Day/Year

Individual Health Record (For Camp Use Only)

Initial Screening **Date/Time:** _________ **Initials:** ____________

☐ **Screening** has been conducted according to camp protocol and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival?........................ ☐ No ☐ Yes as noted below

B. History of exposure to communicable disease?................................. ☐ No ☐ Yes as noted below

C. Additions or corrections to information on this health history?............ ☐ No ☐ Yes as noted below

D. Medication given to health-care staff?... ☐ No ☐ Yes as noted below

E. Any signs/symptoms of head lice?.. ☐ No ☐ Yes as noted below

Provider notes: (date/time/initial all entries) ______________________________

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Exit Note: Check one of the following:

☐ Left camp this day with no reported illness or injury symptoms.

☐ Left camp this day with the following problem/concern:

____

____

This person was told about the problem and instructed about follow-up as noted above: ______________________________

Date/Time: ______________ Initials: __________

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Rev. 1/2007 LEE/EAW

Fill out 1 form per CAMPER

CAMPER HEALTH-CARE RECOMMENDATIONS by LICENSED MEDICAL PERSONNEL FORM 2

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Mail this form to the address below by _______ (date)

***To Parent(s)/Guardian(s): Complete this section** and give **this form** (FORM 2) and **a copy of your completed** CAMPER HEALTH HISTORY FORM (FORM 1) to your child's health-care provider for review.*

Dates will attend camp: from _____________ to ____________
Month/Day/Year — Month/Day/Year

Camper Name: ____
First — Middle — Last

☐ Male ☐ Female Birth Date ____________ (Month/Day/Year) Age on arrival at camp ________

Camper home address: ____

____
City — State — Zip Code

Custodial parent(s)/guardian(s) phone: (_______)_____________ (_______)____________

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. ***Medical personnel:* Cross out those items the camper should not be given.**

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)
- Chlorpheneramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimite)
- Calamine lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today: ☐ Yes ☐ No (**If "No," date of last physical**: ___________) Month/Day/Year

ACA accreditation standards specify physical exam within last 12 months.

Weight: _______ lbs Height: _____ft_____in Blood Pressure_______/_______

Allergies: ☐ No Known Allergies

☐ To foods ***(list):***

☐ To medications: ***(list):***

☐ To the environment ***(insect stings, hay fever, etc.– list):***

☐ Other allergies: ***(list):***

Describe previous reactions:

Diet, Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions:***(describe below)***

The camper is undergoing treatment at this time for the following conditions: *(describe below)* ☐ None.

Medication: ☐ No daily medications. ☐ Will take the following prescribed medication(s) while at camp: ***(name, dose, frequency—describe below)***

Other treatments/therapies to be continued at camp: *(describe below)* ☐ None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes

If you answered "Yes" to the question above, what do you recommend? ***(describe below—attach additional information if needed)***

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print): ______________________ Signature: ______________________ Title: _________

Office Address____
Street — City — State — Zip Code

Telephone: (________)____________________ Date:______________________

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Camper Name ________ First ________ Middle ________ Last ________ (For Camp Use) Cabin or Group ________ (For Camp Use) Session Code(s): ________

CONSENT FOR RELEASE OF PHOTOGRAPHIC REPRESENTATION

This document authorizes People, Incorporated to release photographic representation (still prints, video, and/or digital images)

I, ___________________________, hereby authorize People, Incorporated to utilize photographic
(name)
representation taken on ____7/7/2014-8/15/2014_____ for the following purposes:
(Date)

Please check all that apply:

- o Displays and presentation at People, Incorporated's sites
- o Publication in the People, Incorporated newsletter (which also appears on our website)
- o Publication on the People, Incorporated website
- o Fundraising, promotional and educational material
- o Publication in local, state, and/or national newspapers and/or magazines
- o Other Please specify:____

______ I AGREE to share my photographic image
______ I DO NOT AGREE to share my photographic image

I have had this release explained to me and I understand the content and purposes of the materials being released. I have been given the opportunity to examine the material before it has been released. I further understand that only the above named agency may utilize this material for the purpose of the publication and/or broadcasts specified above, and that no one else may have access to it without my further expressed written consent.

I have not been persuaded into signing this release against my own free will. I understand that my consent may be withdrawn or withheld at any time PRIOR to the release and/or use of said information without punitive action taken against me.

*NOTE: DUE TO THE COST AND TIME INCURRED BY PEOPLE, INCORPORATED FOR PRODUCTION AND DISBURSEMENT OF PUBLICATIONS, VIDEOS, OR DIGITAL IMAGES, PLEASE BE INFORMED THAT ONCE PERMISSION IS GRANTED TO USE A PHOTOGRAPHIC IMAGE AS INDICATED ABOVE, IT CANNOT BE REVOKED AFTER THE IMAGE HAS BEEN SELECTED FOR THE PURPOSE PERMISSION WAS GRANTED FOR.

__________________ ____
Date Name of camper(s)

__________________ ____
Date Parent/Guardian

__________________ ____
Date Witness

Office Use Only

Trip: ______________________

Trip: ______________________

Trip: ______________________

Please keep copy on-site in fieldtrip folder. Forms will be taken on each trip.

Field Trip Permission Form

One permission form per FAMILY

I, the parent/guardian of the camper(s) named below, understand that the Jack Rua Camp for Children with Diabetes may go on a field trip during my camper's time at camp.

I understand that transportation will be by a vendor in partnership with People, Inc. and that the field trip will be free, compliments of the Diabetes Association of People, Incorporated.

I also understand that adequate supervision will be provided and that details of the trip will be sent home with my camper(s) prior to the trip. Those details will include:

- When the trip will take place
- Where the trip will take place
- Approx. time the bus will depart camp
- Approx. time the bus will return to camp
- What items my camper will be expected to bring with him/her

I understand that the Camp Nurse must attend all camp fieldtrip and that no camper will be allowed to remain on the camp site during a field trip. I will make other arrangements for the care of my child/ren in the event that I do not permit him/her to attend a particular field trip.

In the event of an injury requiring medical attention, I hereby grant permission to the supervising personnel to provide medical attention or contact emergency services if necessary. I understand that I will be notified immediately should such a situation arise.

By signing this document (please select one):

☐ I agree to allow my child/ren to go on all camp fieldtrips

☐ I do not agree. I would like an individual permission form for each trip.

Camper(s) Name(s):

Camper #1: ____

Camper #2: ____

Camper #3: ____

Camper #4: ____

Print Name, Parent/Guardian: __________________________________

Signature, Parent /Guardian: __________________________________

Date: ________________

Camp Jack Payment Chart: Please use the payment chart to accurately calculate your camper(s) payment.

- Financial assistance may be available. Please contact us for more information.
- Cities/towns marked with an asterisk* are located outside our service area and subject to a higher rate per week.
- Early registration discounts apply to registrations that have been turned in **with payment** by June 1st 2014.

City/Town of Residence	Child *with* Diabetes Cost per Week	Child *with* Diabetes w/ 10% Early Reg. Discount	Child *without* Diabetes Cost per Week	Child *without* Diabetes w/ 10% Early Reg. Discount
Acushnet	$100	$90	$150	$135
Assonet	$100	$90	$150	$135
Attleboro*	$125	$112.50	$160	$144
Berkley*	$125	$112.50	$160	$144
Dartmouth	$100	$90	$150	$135
Dighton*	$125	$112.50	$160	$144
Fairhaven	$100	$90	$150	$135
Fall River	$100	$90	$150	$135
Freetown	$100	$90	$150	$135
Lakeville*	$125	$112.50	$160	$144
Marion	$100	$90	$150	$135
Mattapoisett	$100	$90	$150	$135
Middleboro*	$125	$112.50	$160	$144
New Bedford	$100	$90	$150	$135
Portsmouth, RI*	$125	$112.50	$160	$144
Providence, RI*	$125	$112.50	$160	$144
Raynham*	$125	$112.50	$160	$144
Rehoboth*	$125	$112.50	$160	$144
Rochester	$100	$90	$150	$135
Seekonk*	$125	$112.50	$160	$144
Somerset	$100	$90	$150	$135
Swansea	$100	$90	$150	$135
Taunton*	$125	$112.50	$160	$144
Tiverton, RI	$100	$90	$150	$135
Wareham	$100	$90	$150	$135
Westport	$100	$90	$150	$135

Request for Financial Assistance

Financial Assistance/Camperships are based upon the Massachusetts Community Development Agency's State Income Guidelines.

Applications **will not be processsed** until all corresonding documents are attached/submitted.
One (1) of the following documents **MUST** be turned into the Diabetes Association as proof of income.

- ✓ Social Security Forms
- ✓ Income Taxes from 2013
- ✓ Two (2) recent paystubs
- ✓ Unemplyment forms/paperwork

Please list ALL campers applying for camperships, beginning with the camper with diabetes.

Camper #1 Last Name:	Camper First Name:	Birth Date:
☐ Camper has Diabetes	☐ Camper is Sibling Name of Camper with Diabetes:	☐ Camper is Friend Name of Camper with Diabetes:
Camper # 2 Last Name:	Camper # 2 First Name:	Birth Date:
☐ Camper has Diabetes	☐ Camper is Sibling (Same as above)	☐ Camper is Friend (Same friend as above)
Camper # 3 Last Name:	Camper # 3 First Name:	Birth Date:
☐ Camper has Diabetes	☐ Camper is Sibling (Same as above)	☐ Camper is Friend (Same friend as above)
Camper # 4 Last Name:	Camper # 4 First Name:	Birth Date:
☐ Camper has Diabetes	☐ Camper is Sibling (Same as above)	☐ Camper is Friend (Same as above)

Camp Jack Financial Assistance Application

Fill out 1 form per FAMILY

Parent/Guardian Name: ______________________________

Address: ______________________________

City/State: ______________________________ Zip: __________

Phone: ______________________________

Family Size (total # of family members living in home): __________

Marital Status: (circle one)

Single Widowed Married Divorced

Camper(s) applying for aid:

Child's Name: ______________________________

Child's Name: ______________________________

Child's Name: ______________________________

Child's Name: ______________________________

For Office Use Only

Date Received: _____ / _____ / _____

Cost to be considered: _________

Aid Awarded: _____% *-or-* ________ off/week

Length of Camp: 1 2 3 4 5 6 weeks

Cost Due per Week: $ _______ per week

Total Cost Due: $ ____________

Date Notified: _____ / _____ / _____

Initials: ________

☐ **I FILED** FEDERAL TAXES FOR LAST YEAR

1040 Federal Tax Form(s) for all incomes in household

☐ I am an individual filing jointly. I am providing ONE 1040 form.

☐ We filed more than ONE tax form in our household. We are providing _____ 1040 forms.

☐ **I DID NOT FILE** FEDERAL TAXES FOR LAST YEAR

-or

☐ **MY HOUSEHOLD INCOME HAS CHANGED** SINCE I FILED MY TAXES LAST YEAR

Documents showing the most recent 30 days of income; including pay stubs or documentation of government assistance, food stamps, and/or child support.

30 days Income x 12 months =Total Annual Household Income of $ ____________

I certify that the above information is true and complete to the best of my knowledge, and that I do not have additional income not represented above. I agree, if necessary, to send additional information and documentation to support the above statements. I understand that financial assistance is based on need. In the event that I or my children must cancel our participation, I will contact the Diabetes Association immediately so assistance can be provided to others. I understand that if I falsify any of the above information, I will not be eligible for assistance now and/or in the future.

Signature: ______________________________ Date: ______________

Credit Card Payment Form

Total Amount Charged to Credit Card $ _________

Name _________________________________

Address _______________________________

City __________________________________

ST ___________ Zip ___________

Method of Payment: Visa __ M/C__ Discover__

____

CID # ______ EXP ______

Signature ________________________________

People, Incorporated is a non-profit 501 (c) (3) organization.

Camper(s) Name(s)

1. ____
2. ____
3. ____
4. ____