

# REGISTRATION FORM- T1D Camper + Optional Sibling/Friend

## Sam Fuld's USF Diabetes Sports Camp 2018

February 3-4, 2018 – University of South Florida Athletic Fields – Tampa, Florida

**Open to Campers Ages 8-17. Register Early - Space is limited!**

T1D Camper's Name:		Birth date:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M	
School Grade:	Date Diagnosed:	Insulin Type(s):		
Street Address: City / State / Zip:			Home Phone:	
Endocrinologist Name: Phone Number:		Insulin Pump? <input type="checkbox"/> Yes <input type="checkbox"/> No Brand:		
Parent/Guardian Name (Mom) : Work phone: Cell phone: Email address: Does child live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		Parent/Guardian Name (Dad): Work phone: Cell phone: Email address: Does child live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the child ever been to diabetes camp?: <input type="checkbox"/> Yes <input type="checkbox"/> No		How did you hear about this camp?		
Name of Optional Sibling or Friend:		Birth date:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M	School Grade:
Street Address: City / State / Zip:			Home Phone:	
Friend's Parent/Guardian Name (Mom) : Work phone: Cell phone: Email address: Does child live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		Friend's Parent/Guardian Name (Dad): Work phone: Cell phone: Email address: Does child live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>T1D CAMPER</b> Please rank the sports below from 1 to 6. #1 is the sport that you are most interested in playing, #6 is the least.  ___ Baseball/Softball (must bring own glove) ___ Tennis – Will you be bringing your own racket? Y/N: ___ ___ Basketball ___ Soccer ___ Football ___ Golf ___ Cheerleading ___ Dance ___ Volleyball  For each of your top three choices, please tell us how many years' experience you have playing: _____ _____ _____  What size T-shirt? ___ (YM, YL, AS, AM, AL, AXL)		<b>FRIEND or SIBLING</b> Please rank the sports below from 1 to 6. #1 is the sport that you are most interested in playing, #6 is the least.  ___ Baseball/Softball (must bring own glove) ___ Tennis – Will you be bringing your own racket? Y/N: ___ ___ Basketball ___ Soccer ___ Football ___ Golf ___ Cheerleading ___ Dance ___ Volleyball  For each of your top three choices, please tell us how many years' experience you have playing: _____ _____ _____  What size T-shirt? ___ (YM, YL, AS, AM, AL, AXL)		

**REGISTRATION & PAYMENT- \$70 PER CAMPER**

Registration fee of \$70.00 per camper includes lunch and snacks on Saturday, and snacks on Sunday, a sports camp t-shirt and water bottle. USF Diabetes Center is offering a \$10 discount to siblings. Please email, mail or fax this form to Florida Diabetes Camps. **Check:** Payable to FCCYD, PO Box 14136, Gainesville, FL 32604

<b>Total Amount: \$</b>	<b>Credit Card:</b> <input type="checkbox"/> MC <input type="checkbox"/> Visa <input type="checkbox"/> Discover If billing address is different than above, please call the office to process.	<b>Name on Credit Card:</b>
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<b>CC#</b>	<b>Exp. Date:</b>	<b>CCV Code:</b>
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## CAMP INTAKE FORM For Camper With Diabetes

### Sam Fuld's USF Diabetes Sports Camp 2017

<b>Camper's Name:</b>	<b>Birth Date:</b>	<b>Date of Diagnosis:</b>	<b>Latest A1C:</b>
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#### Insulin Types and Delivery Method- Please check all that apply

<input type="checkbox"/> Injection/Syringe	<input type="checkbox"/> Humalog	<input type="checkbox"/> NPH	<input type="checkbox"/> 70/30 Novolin
<input type="checkbox"/> Injection/Pen	<input type="checkbox"/> Novolog	<input type="checkbox"/> Levimer (Detemir)	<input type="checkbox"/> 70/30 Novolog
<input type="checkbox"/> Pump	<input type="checkbox"/> Apidra	<input type="checkbox"/> Lantus (Glargine)	<input type="checkbox"/> 70/30 Humulin
	<input type="checkbox"/> Regular		<input type="checkbox"/> 75/25 Humalog

<b>Usual Syringe Dose:</b> AM      Lunch      PM      Bed	<b>Carb ratio:</b>	<b>Correction Factor:</b>
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**Pump Brand:**  Animas     Medtronic     Accu-Chek     Omnipod     T-Slim     Other: \_\_\_\_\_

**Sites used:**  Arm     Leg     Buttocks     Abdomen     Other \_\_\_\_\_

Basal Rates		Carb Ratio		Correction Factor	
Time	Rate	Time	Carb Ratio	Time	Correction Factor

#### Hypoglycemia and Blood Sugar Testing

**Typical blood sugars for:** AM      Lunch      PM      Bed

**Average # of hypoglycemic episodes per week?** \_\_\_\_\_ **Can your child tell when his/her blood sugar is low?** \_\_\_\_\_

<b>Time(s) of Day:</b> <input type="checkbox"/> Breakfast to lunch <input type="checkbox"/> Pre-lunch <input type="checkbox"/> Afternoon <input type="checkbox"/> Pre-dinner <input type="checkbox"/> Other: _____	<b>Typical Symptoms:</b> <input type="checkbox"/> Twitching <input type="checkbox"/> Irritability <input type="checkbox"/> Nausea <input type="checkbox"/> Shaking <input type="checkbox"/> Fatigue <input type="checkbox"/> Pale <input type="checkbox"/> Intense hunger <input type="checkbox"/> Other: _____ <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness	<b>Does your child currently wear a Continuous Glucose Monitor?</b> <b>No:</b> <input type="checkbox"/> <b>Yes:</b> <input type="checkbox"/> Brand: _____
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**Hypoglycemia during/after exercise?(Y/N)** \_\_\_\_\_ **If yes, how severe and how soon after?** \_\_\_\_\_

#### Medical History

**How many diabetes related ER visits in the last 12 months?** \_\_\_\_\_ **List Date(s) and Reason(s):** \_\_\_\_\_

**Please list any other medical problems:** \_\_\_\_\_

**Date and nature of any operations, hospitalizations or injuries:** \_\_\_\_\_

**Other non-diabetes medications:**

Drug Name	Dose	Reason

Please list any allergies and their symptoms:

Does the camper use an epi-pen? *(If yes, please bring it with you to camp)***Immunization History:** (if you have submitted before, add updates ONLY)

Vaccine	Year of Basic Immunization	Year of Last Booster	Vaccine	Year of Basic Immunization	Year of Last Booster
DPT (Diphtheria, Pertussis/ Whooping Cough, Tetanus)			Polio		
TD (Tetanus, Diphtheria)			Chicken Pox		
MMR (Measles, Mumps, Rubella)			Hepatitis B		
TB Skin Test: Most Recent			Tetanus Shot: Most Recent		

**Emergency Information**

Name of family physician:		Phone:	
Insurance company name:		Policy Or Group #:	
Name of family dentist:		Phone:	
Emergency contact name (other than mom/dad):	Relationship:	Home Phone:	Cell Phone:



This packet can be emailed, fax or mailed using the information below.  
 Questions about this form? Please contact Florida Diabetes Camp,

P.O. BOX 14136, Gainesville, FL 32604  
 Tel: (352) 334-1321 Fax: (352) 334-1326

[www.floridadiabetescamp.org](http://www.floridadiabetescamp.org)

Email: [gtc@peds.ufl.edu](mailto:gtc@peds.ufl.edu)



USF DIABETES CENTER  
 UNIVERSITY OF SOUTH FLORIDA

**USF**<sup>®</sup>  
 HEALTH



**SAM FULD'S**  
**USF DIABETES SPORTS CAMP**



# Sam Fuld's USF Diabetes Sports Camp 2018 Authorizations for T1D CAMPER

This page must be completed and signed by a parent or legal guardian for EACH CAMPER. Print, sign and return with registration application. The application will not be considered complete unless this page is signed, dated and returned to the camp office.

**PARENT/GUARDIAN OF ALL PARTICIPANTS MUST SIGN!**

**IN CASE OF EMERGENCY**

I give permission for USF Diabetes Center and/or Florida Diabetes Camp and its personnel to give any medical care necessary for my child and to transport my child to and from Camp and to give her/him any care necessary while in route, and share medical and other relevant information with other care providers.

**Medical Treatment:**

**(Name of camper)** \_\_\_\_\_ has permission to engage in all prescribed camp activities. I hereby give permission to the camp personnel to:

- a) Provide ongoing medical care, including regular blood and urine tests for sugar and acetone and make insulin dose adjustments as necessary.
- b) Select all medical personnel and order any needed x-rays or routine tests or treatment for the camper listed above.
- c) In an emergency the camp medical director may seek to transport my child. The camp medical director may transport, hospitalize, secure treatment for, and order injections, anesthesia and/or surgery for medical or dental problems for the person named above. Every effort will be made to notify the parent.

**My child may be transported to and from the Sam Fuld USF Diabetes Sports Camp on February 3-4, 2018 by:**

Driver Name	Relationship to Camper	Phone number

NOTE: Once campers reach camp and throughout the weekend, the USF Diabetes Center and/or Florida Diabetes Camp will be responsible for all campers. No campers will be allowed to leave the facility until picked up by their designated driver. **No cell phones are allowed during camp!**

**Other permissions:**

I give my permission to the USF Diabetes Center and/or Florida Diabetes Camp and the Directors to transport and admit the person named above to a hospital in the event that medical attention is necessary. This medical attention may include tests, x-rays, anesthesia, and/or surgery for medical or dental problems. I understand that the camp will notify me of any emergency as soon as possible. I understand that the USF Diabetes Center and/or Florida Diabetes Camp is not responsible for injury that may result from accidents, illnesses or other causes.

I give my permission for all of my child's records and information to be shared with the USF Diabetes Center, Florida Diabetes Camp, referring physicians, CMS personnel (if applicable), emergency personnel, and other related health care providers as deemed appropriate by camp staff.

Further, I give my permission for any picture/video taken during camp which includes our child to be published by USF Diabetes Center and/or Florida Diabetes Camp and/or the communications media in any way deemed appropriate by the Directors.

*By entering my full name (First Middle Last) into the field below, I attest to the accuracy of all information contained in this application and associated materials. I acknowledge that my typewritten name in this field constitutes my electronic signature which is equivalent to my legal handwritten signature.*

\_\_\_\_\_ **Date:** \_\_\_\_\_ **Printed Name:** \_\_\_\_\_  
**Parent/guardian electronic signature** (You may also physically sign the form and email, mail, or fax to FCCYD.)

# Camp Intake Form FOR CAMPER WITHOUT Diabetes

## Sam Fuld's USF Diabetes Sports Camp 2018

Camper's Name:		Friend or Sibling with Diabetes:		Today's Date:	
Street Address: City / State / Zip:				Home Phone:	
Parent/Guardian Name(Mom) : Work phone: Cell phone: Email address:			Parent/Guardian Name (Dad): Work phone: Cell phone: Email address:		
<b>Medical History</b>					
Please list any medical problems:					
Date and nature of any operations, hospitalizations or injuries:					
Medications (please bring any needed medications to the camp):					
Drug Name		Dose		Reason	
Please list any allergies and symptoms:					
Does the camper use an epi-pen? <span style="float: right;"><i>(If yes, please bring it with you to camp)</i></span>					
<b>Immunization History: (if you have submitted before, add updates ONLY)</b>					
Vaccine	Year of Basic Immunization	Year of Last Booster	Vaccine	Year of Basic Immunization	Year of Last Booster
DPT (Diphtheria, Pertussis/ Whooping Cough, Tetanus)			Polio		
TD (Tetanus, Diphtheria)			Chicken Pox		
MMR (Measles, Mumps, Rubella)			Hepatitis B		
TB Skin Test: Most Recent			Tetanus Shot: Most Recent		
<b>Emergency Information</b>					
Name of family physician:			Phone:		
Insurance company name:			Policy Or Group #:		
Name of family dentist:			Phone:		
Emergency contact name (other than mom/dad):		Relationship:		Home Phone: Cell Phone:	



# Sam Fuld's USF Diabetes Sports Camp 2018 Authorizations for Sibling or Friend

This page must be completed and signed by a parent or legal guardian for EACH CAMPER. Print, sign and return with registration application. The application will not be considered complete unless this page is signed, witnessed, dated and returned to the camp office.

**PARENT/GUARDIAN OF ALL PARTICIPANTS MUST SIGN!**

**IN CASE OF EMERGENCY**

I give permission for USF Diabetes Center and/or Florida Diabetes Camp and its personnel to give any medical care necessary for my child and to transport my child to and from Camp and to give her/him any care necessary while in route, and share medical and other relevant information with other care providers.

**Medical Treatment:**

(Name of camper) \_\_\_\_\_ has permission to engage in all prescribed camp activities. I hereby give permission to the camp personnel to:

- d) Provide ongoing medical care, including regular blood and urine tests for sugar and acetone and make insulin dose adjustments as necessary.
- e) Select all medical personnel and order any needed x-rays or routine tests or treatment for the camper listed above.
- f) In an emergency the camp medical director may seek to transport my child. The camp medical director may transport, hospitalize, secure treatment for, and order injections, anesthesia and/or surgery for medical or dental problems for the person named above. Every effort will be made to notify the parent.

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Further, I give my permission for any picture/video taken during camp which includes our child to be published by USF Diabetes Center and/or Florida Diabetes Camp and/or the communications media in any way deemed appropriate by the Directors.

*By entering my full name (First Middle Last) into the field below, I attest to the accuracy of all information contained in this application and associated materials. I acknowledge that my typewritten name in this field constitutes my electronic signature which is equivalent to my legal handwritten signature.*

\_\_\_\_\_ **Date:** \_\_\_\_\_ **Printed Name:** \_\_\_\_\_

**Parent/guardian electronic signature** (You may also physically sign the form and email, mail, or fax to FCCYD directly.)