

**2010 NO LIMITS DIABETES
SUMMER CAMP APPLICATION**

When: July 4th to July 10th, 2010
Where: Spring Hill Camp, 90 Minutes South of Indianapolis



Applicant Name: _____

Date of Birth: _____

<<DUE TO THE NATURE AND EXPECTATIONS OF THE PROGRAM, APPLICANTS MUST BE 13 OR OLDER>>

Address: _____

City: _____ State: _____ Zip: _____

Shirt Size: _____

Father's Name: _____ Employer: _____

Mother's Name: _____ Employer: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____ Emergency Phone: _____

Doctor's Name: _____

Doctor's Address: _____

City _____ State _____ Zip _____ Phone _____

Do you have Type 1 Type 2 Diabetes <<BOTH ACCEPTED>>

Medications taken for Diabetes: (Amount and Time Taken)

A. Oral Agents: _____

B. Insulin: _____ Manufactured By: _____

Use Syringe Use Pen Use Pump: Type _____

Pump: Basal Rates: (Start Time and Units Per Hour)

Correction bolus: _____ Carb Coverage: _____

If correction or carb coverage vary during the day list all below: _____

C. Diet: All meals will be served buffet style. Teens are responsible for their own meal selections. Assistance in portion selection is provided. Teens are expected to eat balanced meals and follow proper caloric intake.

Do you use Carb counting Exchanges?

Amounts: Carbs by Meal: _____ Exchanges or Total Calories: _____

D. Other Medications: If you take any other medications than listed above, please list type, amount and time:

The camp is accredited by the American Camping Association which requires that all medications other than insulin, glucagon, and bee sting kits be kept in a locked container.

Insulin, syringes, testing materials and pens will be provided. Pump supplies cannot be provided due to all of the types used. Non-diabetes medications and pump supplies must be provided by the family.

Please list any other health conditions, allergies or developmental situations that might affect our care of your teen during his or her stay at No Limits Diabetes Summer Camp:

Cost of the camp is \$225. Scholarship funds are limited. Every effort will be made to assist with part or all of a scholarship request but it may not be possible. Applications requesting a scholarship should be submitted as early as possible as scholarships will be provided first come first served as long as funds are available. If you are requesting a scholarship, please indicate amount requested \$_____ and reason for request:

Deposit of \$50 is required prior to consideration of the application. All applications will be reviewed by committee so that there may be some delay in notification depending on the next date of application consideration. Applications will be considered by age and ability to participate in an active program. Due to the age group served, a higher level of independent management is expected than by most diabetes camps. The No Limits program is very active and participation to the best ability of each teen is expected. There will be a wide choice of activities with only a limited number that are more inactive. Teens must realize that many of the activities are physically challenging and all are planned to be at high levels of activity.

All active programs carry some inherent risks. Every effort is made to insure that the experience is safe. Careful instructions will be given for all activities. It is our expectation that all participants will follow the safety procedures. No responsibility can be assumed by the camp or No Limits Diabetes for those who do not follow these procedures. If this becomes a significant problem, it is understood that parents will be asked to pick their teen up from camp. Safety is our greatest concern. It is understood that photographs or videos may be made during the camp to be used for promotional and/or publicity. Permission is hereby given.

Applicant Signature

Parent or Guardian Signature

Date

Send with \$50 Deposit to "No Limits Diabetes", 2013 E. Main Street, Danville, IN 46122

For Office Use Only-----

Date received: _____ Amount received: _____