

Camp Kno-Koma Camper Application

Send Applications to: Camp Kno-Koma, 735 Green Valley Dr., St. Albans, WV 25177

General Information

Last Name		First	M.I.	Home Phone
Date of Birth	Sex	Grade in School		Attended Camp Before? ___Yes ___ No Years Attended ____
Street Address			City	
County	State	Zip	E-Mail Address	
Parent(s) or Guardian(s) Name(s)			Work Phone	
Friend or Relative to contact in case of Emergency			Friend or Relative Phone	
Physician Who Manages Child's Diabetes			Office Phone	
Camper's Primary Care Physician (if different than above)			Office Phone	

Insurance Information

Insurance Company	Name of Policy Holder
ID Number or SSN	Group Number
Claims /Customer Service Number	

**Note: Please Attach a Copy of Your Insurance Card
Please Attach a Picture of your Child**

Last Name	First	M.I.
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Insulin Plan

Insulin Type (e.g. Humulin, Novolin, etc.)	A.M. Dose	Noon Dose	5 P.M. Dose	Bedtime Dose

Please list any sliding scales, carbohydrate ratios, or correction boluses here:

Please indicate Humalog with “H” in the dosage spaces above (example: 20N/10H)

If using Novolog please spell out novolog.

Please check here if your child uses an insulin pen device. (If it is not a disposable pen, please send the device to camp with the child)

Insulin Pump Users

Brand of Pump	Infusion Set	Basil Rates
High Blood Sugar Bolus	CHO Bolus	
Note: Campers should bring 3 infusion sets and reservoirs to camp. If Camper uses emla cream or an inserting device, please bring them to Camp.	Length of Tubing for Infusion Set	

Self Management Abilities

Blood Sugar Monitoring <input type="checkbox"/> Alone <input type="checkbox"/> With assistance <input type="checkbox"/> Not at all	Draws Up Insulin <input type="checkbox"/> Alone <input type="checkbox"/> With assistance <input type="checkbox"/> Not at all
Gives Own injection <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Not at all	Rotates Injection Sites <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Not at all
Number of Times that blood sugar is monitored each day _____	

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Diabetes Care

Does your child recognize hypoglycemic reactions (low blood sugars)? <input type="checkbox"/> Yes <input type="checkbox"/> No	How often does your child have hypoglycemic reactions (low blood sugars)? <input type="checkbox"/> Often <input type="checkbox"/> Occasional <input type="checkbox"/> Rare
Has your child ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No	When does your child have most of their low blood sugars?
What kind of symptoms does your child have with low blood sugars?	
How do you treat low blood sugars?	
Please describe anyway that you feel the camp staff can help your child to better understand or deal with his or her diabetes and the importance of self-care.	

Medical Information

Check any of the following problems or illnesses your child may have <input type="checkbox"/> Seizures <input type="checkbox"/> Earaches <input type="checkbox"/> Respiratory Infections <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Asthma <input type="checkbox"/> Emotional Disorder <input type="checkbox"/> Frequent Sore Throat <input type="checkbox"/> Hypertension <input type="checkbox"/> Hayfever <input type="checkbox"/> Bladder Infections <input type="checkbox"/> Skin Problems <input type="checkbox"/> Other _____			
List all medications other than insulin taken by your child:			
NAME	DOSAGE	FREQUENCY	DURATION
Please describe any other significant medical information you may feel is important:			

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Food Plan

What type of food plan does your child follow at home?

- Normal nutrition with a variety of foods, including occasional sweets.
 Vegetarian
 Carbohydrate Counting System. (Fill in grams or choices in table below)
 Other _____

Carbohydrate Counting Chart						
Meal	Breakfast	Snack	Lunch	Snack	Dinner	Snack
# of Carbs						

Please list your child's food allergies/intolerances:

List any special foods your child requires:

Fee Structure for Camp Kno-Koma

In State Residents: \$275.00 if paid by May 31, \$325.00 after payment deadline.

Out of State Residents which either reside in counties which border WV or who are serviced by WV Healthcare Agencies: \$275.00 if paid by May 31, \$325.00 after payment deadline.

Out of State residents: \$400.00 if paid by May 31, \$450.00 after payment deadline.

(For Out of State Campers only)

In order to receive the discounted rate for out of State residents, please complete the following application, and it will be evaluated on an individual basis to determine eligibility.

Also, please remember that a limited number of camper scholarships are available on a first come basis, and priority is given to WV residents.

Application to receive reduced out of state tuition for those border counties, or served by WV Healthcare Facilities.

Last Name		First	M.I.	
Street Address			City	
County	State	Zip		

I am applying for reduced out of state tuition based on the following condition:
(Please check all that apply)

- I live in a county that borders West Virginia.
- I am served by a WV healthcare facility. Please List: _____

I certify that the above statements are true, and I authorize the Diabetes camp of West Virginia to use this information to determine my eligibility for reduced out of state tuition.

Parents' signature: _____

Camp Kno-Koma Camper Medical Application

The child's physician that treats the camper's diabetes must complete this form. This examination should be performed within 12 months before arrival to camp. The examination is for determining fitness to engage in strenuous activities.

Last Name		First	M.I.	Date of Birth
Gender	Height	Weight	Most Recent Hemoglobin A1C	
			Date:	Value:
Blood Pressure	Allergies			

PHYSICAL EXAM

HEENT: WNL Comments: _____

CV: WNL Comments: _____

Resp WNL Comments: _____

GI WNL Comments: _____

Neuro WNL Comments: _____

Genitalia WNL Comments: _____

Skin WNL Comments: _____

May the child participate in strenuous activities? Yes No

Please explain any unsatisfactory or restrictions:
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Physician's Name (Please Print)	Signature	Date

L Send Completed Forms to: Camp Kno-Koma, 735 Green Valley Dr., St. Albans, WV 25177

**SPECIAL DIETARY NEEDS
PHYSICIAN'S MEDICAL STATEMENT**

Student's Name _____ Date of Birth _____

Does this patient have a medical condition/disability that affects her/his diet? Yes or No

Did you refer this patient to a dietitian for diet consultation? Yes or No

If yes, please indicate the consulting dietitian: Name _____ Phone Number _____

Diagnosis or Medical Condition _____

PLEASE MARK ALL AREAS BELOW THAT APPLY, SIGN AND DATE.

DIET RESTRICTIONS	Day Total	Breakfast	Lunch	Snack
Caloric Requirements	1200	_____	_____	_____
	1500	_____	_____	_____
	1800	_____	_____	_____
	2000	_____	_____	_____
Other (Specify Calories)	_____	_____	_____	_____
Carbohydrate Counting (Specify Grams)	_____	_____	_____	_____

Sodium Restriction (**Specify Milligrams**): _____

Fat Restriction _____

Cholesterol Restriction _____

Other Restrictions _____

FOOD ALLERGIES

Food(s) Patient **Can Not** Have

SUBSTITUTIONS

Substitutions **Must Be** Listed

TEXTURE CONSISTENCIES

Solids

Regular Chopped _____

Mechanical Soft
with ground meat _____

Mechanical Soft
with chopped meat _____

Pureed _____

Liquids

Regular _____

Nectar/Syrup _____

Honey _____

Pudding _____

NUTRITIONAL SUPPLEMENTS TO BE PROVIDED AT SCHOOL OR SITE

Please specify amount and frequency of feeding

Oral Feedings _____

Section 504 of the Rehabilitation Act of 1973 assures disabled individuals' access to meals. If an individual has a disabling condition that limits one or more major life activities and requires a special diet, a physician's statement is required. An updated physician's medical statement must be provided at the beginning of each new school year or when any change is prescribed. Schools or sites may make substitutions for non-disabled individuals who are unable to consume the regular meal because of medical or other special dietary needs. A statement from a recognized medical authority, e.g., a medical doctor (MD), doctor of osteopathic medicine (DO), registered nurse (RN), physician's assistant (PA), certified diabetes educator (CDE), nurse practitioner (RNC) or registered dietitian (RD) is required.

Name & Title (print)

Signature

Date

Phone Number _____