CAMPER'S APPLICATION
TENNESSEE CAMP FOR DIABETIC CHILDREN

FRONT AND BACK to be filled out **COMPLETELY** by **PARENTS** and returned immediately to **TCDC**. **Campers Attach Photograph**

Name of Camper ____
Please print (name called by)

Name of Parent or Guardian ______________________ Telephone No. ______________________

Street Address ______________________ City ______________ State ____ Zip ________

Birth Date: __________ Age at Diagnosis ________ Age at Start of Camp: ________ First Time Camper At TCDC? ______________

VERY IMPORTANT INFORMATION

T-Shirt Size **Adult** **Youth** **Name of Insulin(s) Used** **If on Pump (Pump & CGM Name)**

Continuous Glucose Monitor

(Please Circle) **S M L XL** **S M L** ______________ **Pump** __________ __________

(Please Check) **CELIAC DISEASE:** _____ **VEGETARIAN** _____ **VEGAN** _____ **LACTOSE INTOLLERANT** _____

Other medical and psychological conditions ____

Name of Child's **PRIMARY CARE PHYSICIAN** (Please Print) ______________________________

Complete Address ______________________________ Telephone No. ______________________

Name of **DIABETES DOCTOR** (Please Print) ______________________________

Complete Address ______________________________ Telephone No. ______________________

PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARD] [YOUR INSURANCE COVERAGE IS PRIMARY AND TCDC'S COVERAGE IS SECONDARY FOR ALL MEDICAL PROCEDURES]

I wish to enroll the above-named child as a member of the Tennessee Camp for Diabetic Children for the two-week camping period. I understand that participating in TCDC activities involves a certain degree of risk and can be physically, mentally, and emotionally demanding. I also understand that participating in these activities is entirely voluntary and requires participants to abide by all applicable rules and standards of conduct established by TCDC. I have carefully considered the risks involved and give consent for the above-named child to participate in all TCDC camp activities. I release TCDC and all employees, volunteers, related parties, or other organizations associated with TCDC, from any and all claims or liability arising out of this participation.

____
Signature of Parent or Guardian

TWO WEEK SESSION $850 ONE WEEK SESSION $425

Return this Application with a minimum down payment of $100 for each camper which will be NON-REFUNDABLE but will be counted toward the total camping fees. YOUR DOWN PAYMENT MUST BE RECEIVED IN ORDER TO RESERVE A SPOT FOR YOUR CHILD. FULL PAYMENT OF THE CAMP FEE OF $850 OR $425 IS DUE BY MAY 1, 2020.

Make Checks Payable and mail to: **Tennessee Camp for Diabetic Children**
1854 Joseph Ter
Hixson, TN 37343
(423) 843-5006

[..] PLEASE SEND INFORMATION ON FINANCIAL AID
[.. .] WE POST CAMP PICTURES ON OUR WEBSITE, IF YOU DO NOT WANT YOUR CHILD'S LIKENESS TO APPEAR ON THE WEBSITE OR IN PUBLICATION, PLEASE CHECK THIS BOX.

The Tennessee Camp for Diabetic Children is a non-profit organization supported entirely by donations. Anyone able to do so is invited to send a contribution which is tax deductible.

Return to: TENNESSEE CAMP FOR DIABETIC CHILDREN, 1854 JOSEPH TER., HIXSON, TN 37343

This section to be filled in by parent(s)/guardian(s) of minors or by adult campers/staff members themselves.

Name:____ Birth Date:____________ Sex______ Age________
Last First Initial

Parent or Guardian: ________________________________ **Family or Child's E-mail address:**______________________

Home Address: ____ Phone ______________________
Street & Number City State Zip Code Area
Code/Number____________________

Second Parent or Guardian or Emergency Contact: ______________________________ Relationship to Camper ____________

Home Address: ____
Phone______________________________
Street & Number City State Zip Code Area Code/Number

Pursuant to TN law, every custodial parent, guardian or authorized adult must show photo identification and sign a Sign-Out Sheet before a Camper's release.

If not available in an emergency, notify: ______________________________ Relationship to Camper ____________

Address: ______________________________________
Street & Number City State Zip Code Area Code/Number______________

Can child swim? ______________ Special Skills or Talents: ______________ Date of Last Tetanus: ______________

Health History: Check Yes or No if your child has or has had a history of the following. If yes, please describe. **Include a separate sheet if necessary**.

	YES	NO	Medication Name	Dosage	Frequency
Medication Allergies					
Food Allergies					
Celiac Disease					
History of Depression					
History of Hospitalization					
Heart Defect or Disease					
Seizure Disorder					
Dietary Restrictions					
Hypertension					
Asthma					
Disability or Chronic Condition					
Operations or Serious Injuries					
Bedwetter					
Thyroid Disease					

IMPORTANT - THIS SECTION MUST BE COMPLETED FOR ATTENDANCE*

This health history is correct so far as I know, and the above-named child has permission to engage in all prescribed camp activities expected as specifically noted on this form. In signing this form below, I understand that, if any information provided on this form is found to be inaccurate in any way, it may limit and/or eliminate the opportunity for such child to participate in any TCDC event or activity. I grant permission for medical examination adjustments in diabetic regiment, treatment or illnesses, and emergency treatment and/or hospitalization if such is deemed necessary by TCDC, including its Camp Director and Camp Medical Staff. In case of an emergency involving the above-named child, I understand that every effort will be made to contact the parent or individual listed as the emergency contact person. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by TCDC to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for such child. In the case of emergency, TCDC is authorized to disclose protected/confidential health information ("PHI/CHI") as it deems reasonably necessary to any physician and/or healthcare provider involved in providing medical care to the child. PHI under the Standards for Privacy of Individual Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, *et. seq.*, as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the child, follow-up and communication with such child's parents or guardian, and/or determination of the child's ability to continue in TCDC activities. I also authorize release of any and all hospital records of any hospital in which treatment is rendered to my child to any insurance company in which the parent, guardian and/or TCDC carries insurance. This form may be photocopied for use outside of camp.

Signature of parent or guardian or adult camper/staff member:______________________________

Witness:______________________________ Date:______________________________

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of Minor______________________________

*If there are reasons you are unwilling to sign this, then the camp should be contacted for a legal waiver, which must be signed for attendance.