

**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 _____ Age at _____ First Time Camper
Diagnosis _____ Start of Camp: _____ At TCDC? _____

VERY IMPORTANT INFORMATION

T-Shirt Size	Adult	Youth	Name of Insulin(s) Used	_____
(Please Circle)	S M L XL	S M L	If on Pump (Pump Name)	_____
			Continuous Glucose Monitor Name	_____

(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]

How did you hear about TCDC _____

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 \$925 ONE WEEK SESSION (FIRST WEEK ONLY) \$600

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 \$925 OR \$600 IS DUE BY MAY 15, 2024.**

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 _____ Telephone No. _____
 Street & Number City State Zip Code

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: _____

Home Address _____ Telephone No. _____
 Street & Number City State Zip Code

Can child swim? Y/N Special Skills or Talents: _____

Date of Last Tetanus: _____ COVID-19 Vaccination Records (PLEASE ATTACH) _____
 [Recommended by Not Required]
 (Subject to change based on CDC Recommendations)

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 regimen, 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: _____

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.