# LIONS CAMP MERRICK
## 2018 Camp Glyndon Diabetes Program
## Camper Application

The youth listed below desires to participate in the **Lions Camp Merrick Diabetes Program** (a.k.a. Camp Glyndon at Lions Camp Merrick) during the following session(s): (*Sessions are filled on a first come basis*)

Please ☑ the appropriate session(s): ☐ **SESSION 1**: *July 1-6, 2018*

☐ **SESSION 2**: *July 8-13, 2018* ☐ **FAMILY SESSION***: June 27-30, 2018*

**CAMPERS WHO ATTEND MULTIPLE SESSIONS MAY NOT STAY AT THE CAMP OVER THE WEEKEND BETWEEN SESSIONS**

## Camper Information

Camper's name _____ DOB _____ Age @ Camp _____

Sex: Male Female Nick name _____ Race _____

☑**Camper T-shirt size**: **CHILD** small medium large or **ADULT** small medium large XL other ____

Address _____ Phone ( ) _____ City

_____State _____ Zip _____County _____ E-mail

_____ SSN[2]_____ Name of school

attending _____ City _____ State _____

Is camper **Diabetic Type 1**? Yes No **Diabetic Type 2** Yes No **Takes insulin**? Yes No

**Insulin Rx name**: _____ Does camper use a pump? Yes No

[2] The Social Security Number is needed for identification purposes and may be required / used in case of a medical emergency. LCM does not, and will not, release any information regarding the child without the consent of the parent or guardian.

## Parent or Guardian Information

Parent/Guardian _____Relationship _____ Address

_____ Phone ( ) _____ City

_____ State _____ Zip _____ E-mail

_____Cell phone ( ) _____

**Remit $25 non-refundable registration fee along with registration form to:**

**LCM, PO Box 56, Nanjemoy, MD 20662**

**Please make check payable to**: *Lions Camp Merrick* (LCM also accepts Visa, MasterCard and Discover – call for details). **Diabetes Camp fees are $895 per session**; **Family Camp fees are $275 per person** and are due a minimum of 30 days prior to the start of session. *Discounts for multiple registrations.

☐ I am interested in receiving **financial assistance** to send my child to Lions Camp Merrick. Please send sponsorship information and an application package to the address listed above (Parent or Guardian Information).

***Camp Glyndon at Lions Camp Merrick is supported by the American Diabetes Association (ADA)***LCM 3650 Rick Hamilton Place, P.O. Box 56, Nanjemoy, MD 20662

Phone: 301-870-5858 – FAX: 301-246-9108 E-Mail: info@lionscampmerrick.org

Web site: www.lionscampmerrick.org

# LIONS CAMP MERRICK
## 2018 Camp Glyndon Diabetes Program
## NOTICE OF PRIVACY PRACTICES

APPLICANT NAME: _____

*In accordance with the HIPAA (Health Information Portability and Accountability Act), this notice describes how health information about you may be used and disclosed. Please review it carefully. The privacy of your health information is important to us.*

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice took effect April 14, 2003 and remains in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time; provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practice and the new terms of this notice effective for all health information that we maintain, including health information we created or received before we made these changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available to you.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment**: We may use or disclose your health information to a physician or other healthcare professional or provider who is or may be providing treatment to you.

**Payment**: We may use and disclose your health information to obtain payment or assist a medical facility in obtaining payment for services we provided or assisted in providing for you.

**Healthcare operations**: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your authorization**: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

**To your family and friends**: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. This person is the one you have designated on your application to be your emergency contact person.

**Others involved in your healthcare**: We may use or disclose health information to notify, (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or (*continued on pg 3*)

APPLICANT NAME: _____

disclosures (if not a minor). In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Research**: We may disclose your protected health information to researchers when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the information, and approved the research. In addition, we may disclose your protected health information as part of a limited data set for purposes of research, public health or healthcare operations.

**Marketing health-related services**: We will not use your health information for marketing communications without your authorization.

**Required by law**: We may use or disclose your health information when we are required to do so by law.

**Abuse or neglect**: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National security**: We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence and other national security activities.

**Camp practices**: We may use e-mails, voicemail messages, faxes or letters, to obtain your health information pertinent to care that we will provide to you.

**Electronic notice**: If you receive this notice by electronic mail (e-mail), you are entitled to receive this notice in written form. Renewal will be annually.

***Questions**:* If you have any questions or concerns, contact us at the address or phone number below.

| | |
|---|---|
| Contact person: | Donna Wadsworth<br>Administrative Assistant<br>Lions Camp Merrick<br>P.O. Box 56<br>Nanjemoy, MD 20662 |
| Phone: | 301-870-5858 |
| E-mail address: | admin@lionscampmerrick.org |

***In signing this form, you agree that you have read and reviewed a copy of this notice and you also agree that we may disclose health information to the family member (s) and emergency contact person (s) you have designated on your application.***

APPLICANT/PARENT/GUARDIAN SIGNATURE DATE

**LIONS CAMP MERRICK, INC.**
**AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION**
HIPAA (Health Insurance Portability and Accountability Act)

CAMPER'S NAME: _____

CAMPER'S DATE OF BIRTH: _____

NAME OF CUSTODIAL PARENT/LEGAL GUARDIAN: _____

- I hereby authorize Lions Camp Merrick (LCM) to release the above-named Camper's Personal Health Information (PHI) as described below:

The purpose of this disclosure is to promote the ***Camp Glyndon at Lions Camp Merrick*** camp program, to publicize the youth diabetes camp program, and/or to fund-raise for Lions Camp Merrick and/or the American Diabetes Association (ADA), which provide support for this program.

The PHI to be disclosed is limited to the following:

- [ ] Camper photograph or likeness

- [ ] Other: (specify _____)

The PHI may be disclosed as part of Lions Camp Merrick's and/or the American Diabetes Association's marketing efforts, including but not limited to, mailing list development for camp, a brochure promoting camp or other educational program, or fundraising events of Lions Camp Merrick or the American Diabetes Association.

Expiration Date: This Authorization shall expire on December 31, 2021 or not later than the Camper's 18th birthday.

Right to Revoke: I understand that I have the right to revoke this Authorization at any time by giving Lions Camp Merrick written notice of the revocation. I understand that any revocation will not apply to any disclosure that has already been made in reliance upon this authorization.

I understand that I have the right to refuse to sign this Authorization and that my refusal will not affect my child's ability to receive treatment, get payment for treatment, or attend camp.

I understand that I will be given a copy of this signed Authorization. A copy of this document is valid as an original. The original is not required to be shown.

_____
Custodial Parent's/Legal Guardian's Name (print)

_____ _____
Custodial Parent's/Legal Guardian's Signature Date

_____
Relationship to Camper

**Medical Information:** To be completed by parent/guardian (if camper is a minor).
The intent of this information is to provide camp healthcare personnel with background information for appropriate care. Keep a copy of the completed forms for your records.
**THIS FORM MUST BE COMPLETED AND RETURNED THREE (3) WEEKS PRIOR TO YOUR CAMPING SESSION.**

**Applicant Name:**_____

Name and Phone # of family member - **other** than parent/guardian – who will be available in case of emergencies during entire camping session.

Name:_____ Cell Phone:_____

Daytime Phone:_____ Evening Phone:_____

Family Physician _____ Phone:_____

Endocrinologist _____ Phone:_____

Social Worker/Psychologist _____ Phone:_____

Other _____ Phone:_____

Relationship/Title:_____

**Other Information:**

1. Are there any other needs including physical, psychiatric, or behavioral problems of which we need to be aware: _____ NO_____ YES (If YES, please explain)
2. Explain:_____

_____

_____

_____

3. Are there any medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's camp experience is positive? _____ NO _____ YES,
   If Yes, Explain:

_____

_____

_____

_____

**Please include any other information about your child that may help us make his/her camp experience more enjoyable:**

_____

_____

_____

_____

_____

_____

**PERMISSION TO APPLY SUN SCREEN and/or INSECT REPELLENT**

****(**MUST BE SIGNED BY PARENT/GUARDIAN**)****

**I, _____, (parent or guardian)**
**do hereby give permission to allow _____(name of child)**
**and/or the assigned counselors/representatives of Lions Camp Merrick, to apply or to assist with the application of the sun screen and/or insect repellent which has been provided by me, while the child is participating in activities at Lions Camp Merrick in Nanjemoy, MD.**

**Furthermore, I attest that to the best of knowledge, the camper is not allergic to the sun screen and/or insect repellent which has been provided.**

**Name of Sun Screen: _____**

**Name of Insect Repellent: _____**

**Permission granted by:**

**Printed name of Parent/Guardian: _____**

**Signature: _____ Date: _____**

## CABIN ASSIGNMENT

**We assign campers to cabins based on gender and age appropriateness. If you have special request please state here:**

_____

_____

_____

## FRIDAY CHECK-OUT

**The Awards Ceremony is held at 10 A.M. and you are invited to attend. After the program campers will be waiting at their cabins and MUST be signed out by their Parent/Guardian or persons they have designated, at that time your child's moderating will be their responsibility. All camper's check out time is 11:30 A.M. Lunch will be available in the Dining Hall if you would like to eat before you leave. Also, PLEASE check to see you have not forgotten anything before you leave camp. LCM is not responsible for lost or left items.**

**If other than Parent/Guardian, who has permission to pick up camper at the end of camp?**

_____

_____

**Signature of Parent/Guardian: _____**

## Physician's Medical Report To be completed by medical personnel ONLY!

**Problems/Challenges** **Camper Name** _____

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Do you have/ever had Chronic Injury/Illness | ☐ | ☐ | Heart Problems/Chest Pain during/after exercise | ☐ | ☐ |
| Ever been hospitalized or had surgery | ☐ | ☐ | Dizziness/passed out during/after exercise | ☐ | ☐ |
| Had mononucleosis/strep/infectious disease in the past 12 months | ☐ | ☐ | Eating Disorder/Ulcer/Stomach Aches | ☐ | ☐ |
| | | | Diabetes: Type 1 ____ Type 2 ____ | ☐ | ☐ |
| Ever had Tuberculosis | ☐ | ☐ | Hypoglycemia/Low Blood Sugar | ☐ | ☐ |
| Do you have Hepatitis | ☐ | ☐ | Problems with diarrhea/constipation | ☐ | ☐ |
| Glasses/Contacts/Eyewear | ☐ | ☐ | Kidney Problems/Urinary Tract Infection | ☐ | ☐ |
| Ear Infections/Eye Infections | ☐ | ☐ | Bladder Control/Bedwetting | ☐ | ☐ |
| Deaf/HOH | ☐ | ☐ | Problems with joints (knees, ankles, back problems) | ☐ | ☐ |
| Hearing aids ☐ Left ☐ Right | ☐ | ☐ | Have an orthopedic appliance/mobility problems | ☐ | ☐ |
| Asthma/Breathing Problems/Sinusitis | ☐ | ☐ | Skin Problems/Athletes Foot | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Abnormal Menstrual History (female camper only) | ☐ | ☐ |
| Frequent Headaches/Seizures | ☐ | ☐ | Difficulty Sleeping | ☐ | ☐ |
| Ever had head injury/knocked unconscious | ☐ | ☐ | Emotional Difficulties/Compulsive Behavior/ Inattention | ☐ | ☐ |
| Other | ☐ | ☐ | Was help sought for any of the above? | ☐ | ☐ |

***If answered yes to any of the above, please explain:***

**Dietary Restrictions:** **Does not eat**: ☐ Red meat ☐ Eggs ☐ Dairy ☐ Pork ☐ Poultry ☐ Seafood ☐ Other:_____
**Other restrictions or limitations:** (what cannot be done, what adaptations or limitations are necessary)

**Medications: (check one)** ☐ **Applicant takes NO medications on a routine basis.**

☐ This person takes medications, see below.

Please list all medications being taken routinely (including over-the-counter or non-prescription drugs). Bring enough medication to last the **entire time at camp**. Keep all medication in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of dosage.

Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Med #3 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Attach additional pages for more medications. Identify any medications taken in the past year that participant will/will not take during the summer ( i.e. Ritalin, Zoloft): _____

# Physician's Medical Report — To be completed by medical personnel ONLY!

Applicant Name:_____ DOB:_____ SEX: M F

Which of the following has the applicant had or has been exposed to?

| | |
|---|---|
| ❒ Measles | ❒ Mumps |
| ❒ German Measles | ❒ Tuberculosis |
| ❒ Chicken/Small Pox | ❒ Diphtheria |
| ❒ Hepatitis A | ❒ Mono |
| ❒ Hepatitis B | ❒ Strep |
| ❒ Hepatitis C | ❒ Polio |
| ❒ Rheumatic Fever | |

**Immunization Record**. All Applicants under 18. Please give dates of immunization **or attach current copy**. (Out of state participants must comply with Maryland requirements.)

| Vaccine | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr |
|---|---|---|---|---|---|
| PT/TD | _____ | _____ | _____ | _____ | _____ |
| Polio | _____ | _____ | _____ | _____ | _____ |
| Measles | _____ | _____ | _____ | _____ | _____ |
| Mumps | _____ | _____ | _____ | _____ | _____ |
| Rubella | _____ | _____ | _____ | _____ | _____ |
| Haemophilus Influenza | _____ | _____ | _____ | _____ | _____ |
| Hepatitis B | _____ | _____ | _____ | _____ | _____ |
| Varicella | _____ | _____ | _____ | _____ | _____ |

Height: _____ Weight: _____ Pulse: _____ Respiration: _____ BP: _____

Date of last Glycosolated Hemoglobin: _____/_____/_____ Result:_____ Normal Range:_____

Tuberculosis/Mantoux Test Must be within last 12 mo. (STAFF 18 and Over) Date of last test _____ Result: Positive Negative

**Health Care Recommendations by licensed Medical Personnel**

The purpose of this examination is to determine that the applicant is physically fit to engage in strenuous camping activities without harm to him/herself and does not have a contagious or infectious condition that could be conveyed to others.

**CODE: Satisfactory = X Unsatisfactory = U** (EXPLAIN CONDITIONS BELOW) **Not Applicable = NA**

| | | | | |
|---|---|---|---|---|
| ____ Eyes | _____ Glasses | ____ Ears | ____ Hearing Impaired | ____ Hearing Aids Left/Right |
| ____ Heart | _____ Teeth | ____ Nose | ____ Throat/Tonsils | ____ Lungs |
| ____ Extremities | _____ Feet | ____ Athlete's Foot | ____ Posture | ____ Abdomen |
| ____ Hernia | _____ Urinalysis | ____ Genitalia | ____ Menstrual History | ____ Other |

Explanation of Unsatisfactory Findings: _____

_____

List any illnesses, surgery or infectious diseases the applicant may have had in the last twelve (12) months: _____

_____

**In my opinion, the above individual (IS / IS NOT) able to participate in an active camp program.**

**Restricting Condition and Explanation**:_____

_____

Medications to be taken at camp (name, dosage, frequency): ***Please attach additional pages if needed.***

_____

_____

Known allergies: _____

_____

Any medically prescribed meal plan or dietary restrictions: _____

_____

Any other health problems, physical or emotional disabilities:_____

Additional information for heath care staff at camp: _____

**Name, contact information and signature of Physician or Other Licensed Personnel (REQUIRED)**

Print Name:_____ Title (if other than physician)_____

Address: _____City: _____State: _____

Zip: _____Phone: _____Date: _____

_____ **My License expires on:** _____

Signature: _____ _____

Insurance Information and Authorizations

Applicant Name:

Insurance: Please attach a copy of your Insurance or Medicaid Card. Also, attach completed and signed insurance forms along with referrals/authorizations if they are appropriate.

Insurance Co._____ Policy _____Group_____
Subscriber's Name_____ Relationship to camper _____
Claims Address:_____City_____State_____ Zip _____
Insurance Co. Telephone (_____)_____
Medicaid/Medicare Card # _____ Cardholder Name _____
Eligible for Medicaid Yes ____ No ____ From Date: _____ Expiration Date: _____

Authorizations:

Insurance/Services: I understand that there is no group medical coverage for services rendered or to be rendered and I hereby assign and transfer any benefits otherwise payable to me for my benefit under hospitalization, health or accident insurance, any other insurance coverage, to include major medical benefits, for the payment of services rendered. If a Medicare or Medicaid patient, I certify that the information given by me in applying for payment under TITLE XVII of the Social Security Act is correct. I request that payment of authorized benefits be made in my behalf. I understand that regardless of my assigned insurance benefits, I am responsible for total charges in consideration for services rendered

INITIALS _____

Medical Release: I authorize release of any medical information requested by representatives of local, state or federal agencies, insurance companies or other organizations as may be required. The health history is correct and complete as far as I know. I give permission to the camp to provide routine health care, administer prescribed medications, as well as over the counter medications (including sunscreen and insect repellent), and seek emergency medical treatment onsite or via EMT, Ambulance and/or including x-rays or routine tests. (In addition, For Diabetes Camp ONLY I give permission for insulin dosage changes and daily glucose monitoring as deemed necessary by the NP or physician.) I agree to the release of any records necessary for insurance purposes. I authorize the Camp to arrange emergency and follow-up related transportation. In the event a family member or guardian cannot be reached in an emergency, I authorize the physician selected by the camp to secure and administer treatment, including hospitalization, injection, anesthesia or surgery as well as follow-up treatment as needed.

INITIALS _____

HIV: I authorize the Camp medical staff to make arrangements and obtain specimens for documentation of the HIV/HBV status on the person named above. I understand this will only be performed in a situation of an occupational exposure incident that involves the camper/staff. An occupation exposure incident is defined as a situation when camper/staff has been in contact with blood, body fluids or potentially infectious materials from a camper/staff (e.g. the employee accidentally touches a bleeding wound). Regulations require that we perform measures to prevent exposure incidents; however, if an incident does occur, the staff and camper involved should be tested. Blood tests will be performed by a nearby local hospital/clinic. I understand that all results will be given to me and that the Camp will not disclose the results of these tests to others except as required by law or as necessary to safeguard the well being of health care professionals, Camp medical staff, or other persons at risk. I understand that the absolute confidentiality of the test results cannot be guaranteed although all measures required by law to ensure confidentiality will be followed and that the results will be placed in the Lions Camp Merrick Exposure Control record in the camp office.

INITIALS _____

Hold Harmless: I do hereby agree to indemnify and hold Lions Camp Merrick and its directors, agents, volunteers, and/or employees harmless from any and all damages, claims, expense or costs of whatever nature, causes of action, suits and liability of every kind including attorney fees, for injury to or death, or for damage to any property, arising out of or in connection with use or occupancy of the premises or participation in the Camp programs, except where such injuries, death or damages are caused in whole or in part by the negligence of Lions Camp Merrick, or joint negligence of Lions Camp Merrick and any other person or entity employed by the Camp.

INITIALS _____

Search and Seizure: As a condition of participation and in order to provide a safe environment for all persons, Lions Camp Merrick adopts a policy of reasonable search and seizure of any person or personal property in situations of suspected theft, illegal drugs, or possession of contraband items such as weapons, fireworks and alcohol. Your initials and signature on this document will be deemed as a written consent to such reasonable searches and seizures and a waiver of all claims against Lions Camp Merrick for conducting the same.

INITIALS_____

Consent: The applicant agrees to attend and participate in activities at Lions Camp Merrick. I understand that the program may include field trips and canoe trip/over-night camp outs which may include transportation from and to the Camp and give permission to participate in such field trips, high ropes, low ropes, swimming, sports games and archery. I understand that pictures, audiotapes, and videotapes may be taken for use in publicity that is in the proper interest of the Camp and agree to this.

INITIALS _____

_____ _____ _____
Signature of parent/guardian/applicant Printed name of parent/guardian/applicant Date

## INSULIN DOSES INFORMATION FORM

**To be completed by parent/guardian (if camper is a minor)**

Applicant's Name:_____ DOB:_____ Session(s) _____

Does the applicant usually give his/her own injections? Yes _____ No _____

Insulin Regimen (circle all that apply):

**Brand:** EliLilly Novo-Nordisk

**Type:** NPH Regular Humalog UltraLente 70/30 Humalog 75/25
Lente Novalog Lantus 50/50 Other: _____

**Devices:** Pen Injector Pump Other: _____

What is applicant's insulin routine at the present time? (include amount and type of insulin):
**(Dosages may change prior to camp. Please bring an updated copy of applicant's insulin regimen on day of check-in.)**

| | **TYPES AND UNITS** (example: 15N/3H) | **PUMP DOSES** List basal rates and meal boluses below | |
|---|---|---|---|
| Breakfast | _____ | _____ | _____ |
| Snack | _____ | _____ | _____ |
| Lunch | _____ | _____ | _____ |
| Snack | _____ | _____ | _____ |
| Dinner | _____ | _____ | _____ |
| Snack | _____ | _____ | _____ |

(Attach Sliding Scale on another sheet if necessary)

Does applicant have an insulin pump? Yes No

If yes, which type and brand name?_____

What is their CHO: Insulin ratios? _____

What is the sliding scale you use when applicant is above target? _____

Does applicant require any assistance with operating the pump or infusion set? Yes No If yes, please explain:

_____

How often does applicant experience low blood sugars? Occasionally Frequently Never

Does applicant recognize early signs of low blood sugars? Yes No

What are applicant's symptoms (blurry vision, shaky, sweaty hands)? _____

What do you use to treat low blood sugar? _____

Has applicant ever had a severe low and/or a hypoglycemic seizure? Yes No If yes, when?_____

How do you feel applicant has adjusted to diabetes? _____

_____

What goals, concerns or recommendations do you have for the applicant while at camp?

_____

_____

**LIONS CAMP MERRICK**
**Meal Plan**

To be completed by Parent/Guardian (if applicant is a minor)

Applicant's Name: _____

Please be sure to complete all appropriate sections of this form. It is also important that accurate information is given. Please do not list what your prescribed meal plan is unless that is what you follow at least three quarters of the time. We want to know what you are actually eating.

While at camp, diets may be altered to accommodate the increased energy needs often required because of more vigorous activity. Be assured that a Registered Dietician, who works often with children and adolescents with diabetes, will be making any changes that are necessary.

Usual Meal Plan at Home – please check one:

_____ No Concentrated Sweets _____ Exchange Lists _____ Carbohydrate Counting

Please record pattern: _____

_____

_____

Exchange Pattern; Specify number of Calories: _____

Please record pattern: _____

_____

_____

Please list two examples of foods and amounts for meals/snack that might be eaten. (If the applicant is over 12 years old, please allow them to complete this section). We will use the examples given to devise a meal plan. Please be sure this information is as close to usual as possible.

BREAKFAST
Example 1: _____
Example 2: _____

MORNING SNACK
Example1: _____
Example 2: _____

LUNCH
Example 1: _____
Example 2: _____

AFTERNOON SNACK
Example 1: _____
Example 2: _____

EVENING MEAL
Example 1: _____
Example 2: _____

BEDTIME SNACK:
Example 1: _____
Example 2: _____

# Lions Camp Merrick
## *Behavior Policy*

In order to ensure a safe, healthy environment for all campers, the following rules will apply and will be strictly enforced:

1. Applicants will not be abusive toward others or self.
2. Applicants will not take or misuse items/property belonging to other applicants, staff or the camp facility.
3. Applicants will follow instructions given by counselors/staff having supervisory responsibility over them.
4. Applicants will stay on camp property at all times and will not leave designated areas without permission.
5. The possession of cell phones and/or electronic equipment is not permitted at camp.
6. Use of alcohol (beer, wine, liquor), tobacco products, and /or illegal drugs is not permitted.
7. Possession of weapons is not permitted.

Breaking the rules will result in immediate dismissal from camp without refund.

Lions Camp Merrick reserves the right to inspect all applicant's luggage, including personal belongings, at any time during the camp session.

APPLICANT:

*I understand and agree to abide by the above rules and to any restrictions placed on my participation in camp activities.*

Applicant Name: _____ Session(s) _____

_____ _____
Signature of Applicant Date

PARENT/GUARDIAN

*I understand the above rules and consent to the above discipline policies of Lions Camp Merrick. I agree that if called to pick up my child due to discipline reasons that I must make arrangements for pickup on the same day as called. (Lions Camp Merrick reserves the right to call in County Child Services if a child is not picked up).*

_____ _____ _____
Signature of Parent/Guardian Relationship Date

# LIONS CAMP MERRICK
## Swimmer Ability Form

*This form will be made available to the Waterfront/Water Safety Instructor (s).*

Camper Name: _____ Nick Name:_____ Session(s):_____

Age: _____ Gender: _____ Weight: _____ Height: _____

Swimming Abilities (circle the correct response):

| | | | | |
|---|---|---|---|---|
| 1. | Is camper independent in shallow water? | Yes | No | unknown |
| 2. | Is camper independent in chest-high water? | Yes | No | unknown |
| 3. | Is camper independent in deep water? | Yes | No | unknown |
| 4. | Is camper afraid of water? | Yes | No | unknown |

If answered yes, please describe any experience in the past that might have caused such a fear:

_____

5. Will camper need assistance getting in or out of the pool? Yes No

6. Can camper swim independently? Yes No

If yes, describe swimming strokes and techniques he or she can do:

_____

7. Is camper sensitive to pool water in any way? (allergies, sensitive to sun, ear trouble, etc). Yes No

Explain as necessary _____

8. Does camper need or use a flotation device? Yes No

9. Please list any special concerns we should be aware of:

_____

_____

_____ _____

Signature of Parent/Guardian Date

**Please return this form along with the forms listed below to the Camp Administrative Office:**

I have enclosed the following:

- ❑ Notice of Privacy Practices – HIPAA Form which is signed and dated**.**
- ❑ Insurance/Authorizations Form - completed, initialed and signed.
- ❑ Medical Information Form - completed and signed.
- ❑ Physician's Medical Report along with Immunization Record - signed and dated.
- ❑ Insulin Dose Information Form (Diabetes Camp Only) – completed.
- ❑ Meal Plan Form (Diabetes Camp Only) – completed.
- ❑ Behavior Policy - signed and dated.
- ❑ Swimmer Ability Form - completed, signed and dated.
- ❑ I have included a check or money order for the appropriate camper fee.
- ❑ A one-time $25 Registration Fee has been submitted. (this is included in your session fee)
- ❑ **I HAVE ENCLOSED A FRONT AND BACK COPY OF APPLICANTS INSURANCE CARD AS WELL AS A RECENT PHOTO.**

Return all forms to:

Lions Camp Merrick
PO Box 56
Nanjemoy, MD 20662

Or email to:
admin@lionscampmerrick.org

-Or-

Fax to: 301-246-9108

**PLEASE ATTACH CAMPER PHOTO HERE**

**Camper Name:** _____

**Please submit forms by May 15th, or at least three weeks prior to camping session**