

DYS BIG SHOTS RESIDENT CAMP 2009
GENERAL INFORMATION

For camper security
and safety, please
insert a current
photograph here.

All forms must be in the DYS office by **June 1, 2009** to confirm placement.
Please allow seven days for delivery time if using the U.S. Postal Service.

Mail to: **Diabetes Youth Services**
5871 Monclova Road
Maumee, OH 43537

If you cannot mail the form in time, you must make arrangements with the DYS office staff to bring them to the office, they CANNOT be faxed! Call (419) 887-8739 to make arrangements and to ensure staff will be available.

FORMS WILL NOT BE ACCEPTED AFTER JUNE 1, 2009

CAMPER CONTACT INFORMATION

Camper Name: _____ M/F: _____ Soc # _____ - _____ - _____
Birth Date: ____/____/____ Age on 6/21/09: _____ School grade in fall: ____ School attending in fall: _____
Current Residence: _____ City: _____ ST: ____ Zip: _____
Home phone: (____) _____ - _____ E-mail: _____
Living with child in current residence: Mother Father Stepmother Stepfather Grandmother Grandfather
Foster Mother Foster Father Aunt Uncle

Mother or legal guardian name: _____
Address (if different from child's): _____
Home phone: (____) _____ - _____ Cell phone: (____) _____ - _____ Other: (____) _____ - _____
Place of employment: _____ Work phone: (____) _____ - _____

Father or legal guardian name: _____
Address (if different from child's): _____
Home phone: (____) _____ - _____ Cell phone: (____) _____ - _____ Other: (____) _____ - _____
Place of employment: _____ Work phone: (____) _____ - _____

Parent/Guardian to reach during daytime: _____ Ph: (____) _____ - _____

Are there any custody or visitation issues that camp should be aware of at this time? YES NO
If yes, please explain: _____

Parents'/Guardians' address if different during camp session: _____
Phone if different: (____) _____ - _____ Dates at this location: _____

HEALTH CARE PROVIDERS INFORMATION

Physician for Diabetes Care _____ M.D/D.O. Fax# (____) _____ - _____
Physician Address: _____
Street City State Zip
Daytime Phone (____) _____ - _____ Nights/Weekend Phone (____) _____ - _____

Camper's Physician (Pediatrician) _____
Physician Address: _____
Street City State Zip
Camper's Dentist _____ Phone: (____) _____ - _____

Do we have permission to speak with your child's health care providers? YES NO

Camper name: _____

Age: _____

INSURANCE INFORMATION

Medical Insurance Company: _____

Name of Policy Holder: _____

ID Number _____ Group Number _____

Policy Holder Employed By: _____

Prescription Coverage (if different): _____

Name of Policy Holder: _____

ID Number _____ Group Number _____

Prescription Policy Holder Employed By: _____

Other Medical Financial Assistance:

_____ Bureau of Children with Medical Handicaps (BCMh) _____ Medicaid

Name of Policy Holder: _____ I.D. Number: _____

PLEASE PROVIDE COPIES OF THE FRONT AND BACK OF ALL INSURANCE AND PRESCRIPTION CARDS

OTHER INFORMATION

Help us to understand your child so that they will have a HAPPY, SAFE, CONFIDENCE-BUILDING camp experience. PLEASE include difficulties **with diabetes management, physical, emotional and psychological needs, behavioral problems, eating problems, social concerns, possibility of homesickness**, etc., and the techniques you find useful in supporting your child. This information is extremely important in helping us provide the *best possible* camp experience for your child and their camp peers. (Please attach another sheet if needed.)

I understand that my child will have a thorough head lice exam at check-in. I further understand that if my child has any signs of lice infestation, my child will not be able to attend camp.

Signature of Parent or Guardian

Date

The information provided on this form is complete and accurate to the best of my knowledge.

Signature of Parent or Guardian

Date