

**DYS LITTLE SHOTS DAY CAMP 2009**  
**General Information Form**

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

All forms and fees must be in the DYS office by **July 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, Ohio 43537

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

**FORMS WILL NOT BE ACCEPTED AFTER JULY 1, 2009**

**CAMPER CONTACT INFORMATION**

Camper Name: \_\_\_\_\_ M/F: \_\_\_\_\_ Soc # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age on 7/14/09: \_\_\_\_\_ 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