

Do You Need a Ride?

Please check tentative location that would most benefit you.

- HIGHLAND MALL
 PALMER AUDITORIUM
 LAKELINE MALL

Yes, I am interested in daily Bus Service for my child. Please send me more information about this service.

NAME OF INSURANCE PROVIDER:

POLICY HOLDER'S NAME:

HEALTH INSURANCE INFORMATION

ADDRESS OF INSURANCE PROVIDER:

PHONE NUMBER:

POLICY NUMBER (IN CASE OF EMERGENCY):

PARENT ORIENTATIONS

Please circle the date of the session you will attend.

June 5th 7pm - 8pm

June 8th 10am - 11am

AT SETON HOSPITAL

VOLUNTEER ORIENTATION

June 8th 9am—2pm

AT PEACEABLE KINGDOM

(MORE INFORMATION TO FOLLOW)

PARENT WAIVER

(Parent to complete by initialing and signing bottom.)

_____ I/We hereby give my/our consent for _____ to attend and participate in all activities of Camp Bluebonnet and hereby agree to hold harmless Camp Bluebonnet and/or its sponsors, its agents, servants or employees from any and all liability of whatsoever nature and injuries, sickness or other damages suffered by us or camper during his or her stay at Camp Bluebonnet and by any act of omission of said organization, their agents, servants or employees.

_____ I/We authorize the medical staff of Camp Bluebonnet to administer or authorize emergency medical treatment in our absence. We understand that every reasonable effort to notify us will be made prior to rendering treatment.

_____ In addition, I authorize the American Diabetes Association to release pictures, photographs, slides or movies for publicity or public usage.

PRINT FULL NAME:

SIGNATURE OF PARENT OR LEGAL GUARDIAN:

TELEPHONE (EMERGENCY USE ONLY):

THE AMERICAN DIABETES ASSOCIATION DOES NOT DISCRIMINATE BASED ON RACE, CREED, NATIONAL ORIGIN, GENDER OR SPECIAL NEEDS.

Camp Bluebonnet 2002

**June 10-14, 2002
Peaceable Kingdom
(20 Minutes West of
Salado on 2484 in
Youngsport)**



"A unique camping experience for kids with diabetes...their siblings...and their parents."

Camp Bluebonnet is designed and operated by:



in conjunction with:

**CHILDREN'S HOSPITAL
OF AUSTIN**

CAMP BLUEBONNET 2002

Camp Bluebonnet is a day camp providing camping for young people between the ages of 4 and 12 who have diabetes, and their siblings. Camp Bluebonnet, accredited by the American Camping Association, provides a safe, medically supervised camping experience for children with diabetes. Daily programs include essential diabetes education, as well as swimming, archery, canoeing, hiking along dinosaur tracks, arts & crafts, and more--all in a relaxed atmosphere with their peers.

June 10-14, 2002 · from 9am - 3:30pm
Registration begins at 8:30am
Send completed application by May 1 to:
One Application Per Person

AMERICAN DIABETES ASSOCIATION
ATTN: CAMP BLUEBONNET
815 BRAZOS SUITE 200
AUSTIN, TEXAS 78701
(512) 472-9838

No refunds will be available if cancellation of the application is received after May 14.

Camp will be limited to 200 campers.
Therefore, late or incomplete applications may not be accepted.

For Questions About Camp, Contact:
 Elizabeth Williams, RN CDE
 (512) 324-8864



CAMPER APPLICATION

CHILD'S NAME: _____

DOES THIS CHILD HAVE DIABETES? YES _____ NO _____

MOTHER'S/GUARDIAN(S) NAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE-HOME: (____) _____

PHONE-WORK: (____) _____

EMPLOYER: _____

FATHER'S/GUARDIAN(S) NAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE-HOME: (____) _____

PHONE-WORK: (____) _____

EMPLOYER: _____

CHILD'S AGE: _____ BIRTH DATE: _____

ETHNICITY: _____ SEX: M / F _____

CHILD'S NEXT GRADE: _____ SCHOOL NAME: _____

HAS CHILD ATTENDED CAMP BLUEBONNET BEFORE? _____

IF YOU WILL BE A CIT, WHICH AGE GROUP DO YOU PREFER

TO BE GROUPED WITH? _____

AGE	STATUS	FEE
13+	COUNSELOR IN TRAINING (CIT)	\$30
4-12	CAMPER WITH DIABETES	\$35
6-12	SIBLING CAMPER	\$35

MAKE CHECKS PAYABLE TO
AMERICAN DIABETES ASSOCIATION
815 BRAZOS SUITE 200



PHYSICIAN TO COMPLETE

CHILD'S HEIGHT: _____ WEIGHT: _____ BP: _____

ALLERGIES: _____

OTHER MEDICAL CONDITION(S): _____

OTHER MEDICATION(S) & DOSAGE: _____

IMMUNIZATION DATES:

DPT-Td: _____ MMR: _____

OPV: _____ TB: _____

SIGNATURE OF PHYSICIAN: _____

PLEASE PRINT NAME OF PRIMARY CARE PHYSICIAN:

ADDRESS: _____

CITY: _____ STATE: _____

ZIP: _____ PHONE: (____) _____

PLEASE PRINT NAME OF PHYSICIAN FOLLOWING DIABETES CARE:

ADDRESS: _____

CITY: _____ STATE: _____

ZIP: _____ PHONE: (____) _____

PARENT TO COMPLETE

If Applicant does not have diabetes, please skip this section.

ONSET OF DIABETES (MONTH/YEAR): _____

AGE AT ONSET: _____

BRAND/TYPE OF INSULIN: _____

METHOD OF INSULIN DELIVERY: (CIRCLE ONE) PUMP OR INJECTION

DILUTION: _____

IF PUMP - INSULIN TO CARB RATIO: _____

IF PUMP - CORRECTION FACTOR: _____