**ATTACHMENT A**

# DIABETES MANAGEMENT PLAN

***[Description of Winnewald Day Camp's Activities, hours, etc.]***

This plan should be completed by both the child's health care provider *(diabetes nurse educator, endocrinologist, or primary care provider/physician)* and the child's parent/guardian.

It should be immediately updated with any new information, as necessary.

Effective Dates: ______________________________________________________________
Child's Name: ________________________________________________________________
Date of Birth: ________________________________________________________________
Physical Condition: ____________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
Date of Diagnosis: _____________________________________________________________
Grade: ______________________________________________________________________

Contact Information: *Circle the primary contact person and phone number*
Parent/Guardian: ______________________________________________________________
Home Address: ________________________________________________________________
Employer: ____________________________________________________________________
Employer's Address: ____________________________________________________________
Telephone: Home ________________ Work _________________ Cell ___________________
Parent/Guardian (2): ____________________________________________________________
Home Address: ________________________________________________________________
Employer: ____________________________________________________________________
Employer's Address: ____________________________________________________________
Telephone: Home ________________ Work _________________ Cell ___________________
Who has custody of the child? ____________________________________________________

Child's Health Care Provider:
Name: _______________________________________________________________________
Address: _____________________________________________________________________
Telephone: ___________________________________________________________________
Emergency Number: _____________________________________________________________

Other Emergency Contacts:
Names: ___________________________________________________________________
Relationship: _______________________________________________________________
Telephone: Home ________________ Work _________________ Cell ___________________

Notify parent/guardian or emergency contact in the following situations: ___________________
_____________________________________________________________________________
_____________________________________________________________________________

Recommended Monitoring of Child: _______________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Specify any medical time requirements: ____________________________________________
_____________________________________________________________________________

Can child perform own monitoring? ❑ Yes ❑ No
Exceptions: _________________________________________________________________
_____________________________________________________________________________

Identify the type of any meter, monitor, nebulizer, applicator, needle, pump, or any other devices necessary for the child's Diabetes Management Plan *(include model and instruction booklet)*:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

What signs does the child demonstrate when child is symptomatic: _______________________
_____________________________________________________________________________
_____________________________________________________________________________

Foods to avoid, if any: _________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Instructions for when food is provided to the child *(e.g. as part of a party or food sampling event):* ____________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Exercise and Sports Limitations:
List, identify, and explain any restrictions to exercise, sports, or any other activities: _________
_____________________________________________________________________________
_____________________________________________________________________________

Treatment supplies to be kept at the Summer Camp site and provided by parent/guardian are as follows *(please provide specific instructions regarding the storage and treatment of all supplies)*:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

***For children with medical concerns, please complete the supplemental form.***

**This Diabetes Management Plan has been approved by:**

_________________________________________ ________________________________

Child's Physician/Health Care Provider Date

I give permission to Winnewald Day Camp to perform and carry out the care tasks as outlined in the Diabetes Management Plan. I also consent to the release of the information contained in this Diabetes Management Plan to all staff members and any other adults who have custodial care of my child, such as those persons on the emergency list and who may need to know this information to maintain my child's health and safety. A written revocation or amendment to this document must be delivered to the summer camp director by the child's Parent/Guardian in order to effectuate a revocation of the same.

The Camp reserves the right to request additional documentation after review of the information contained in the document.

**Acknowledged and received by:**

_________________________________________ ________________________________

Child's Parent/Guardian Date

_________________________________________ ________________________________

Child's Parent/Guardian Date

## ATTACHMENT B

## PHYSICAL EXAMINATION

**[To be completed by Parent/Guardian and Child's Health Care Provider.]**

**To Parent/Guardian:** Please complete the information in the box BEFORE submitting to your child's health care provider:

Name of applicant: ____________________________________________

Gender: (circle one) M F

Date of Birth: ____________/______________

Address: _____________________________________________________
_____________________________________________________________

**To Child's Health Care Provider:** This form should be completed and approved by the child's diabetes nurse educator, endocrinologist, or primary care provider/physician. Your cooperation in supplying the following information about an applicant for the Winnewald Day Camp is greatly appreciated. The child will not be accepted without your approval on this form.

Date of most recent exam: ______________________________________________________

I have read the Diabetes Management Plan, attached to this form, and certify that it provides a complete regimen of care for this child's safety during summer camp. I recognize that the child will be active at this camp and represent that this plan accounts for all applicable varying activity levels. Any restrictions are noted below.

Have any complications of health been detected? Yes / No (circle one)
If yes, please specify: ____________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Is the child emotionally and physically mature or responsible enough to independently manage his/her health concerns? Yes _____; No _____. If not, please explain the minimum level of the medical licensure or training required for the child's safety (unless fully described in the Diabetes Management Plan): ______________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Do you have any specific concerns regarding the management of this child's safety or health at camp not fully described in the Diabetes Management Plan? Yes ____; No ____. If yes, please explain: ______________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Do you recommend any limitation on child's activity while at camp beyond those described in the Diabetes Management Plan? Yes ____; No ____. If yes, please describe: ______________

______________________________________________________________________________

______________________________________________________________________________

I certify that the information above is correct to the best of my knowledge and agree to answer questions and provide management guidance to the ___________________________________ camp program as requested at the sole cost and expense of the parent/legal guardian of the child.

Primary Health Care Provider's Name: (typed or printed)

______________________________________________________________________________

Address: ______________________________________________________________________

______________________________________________________________________________

Phone: (____)__________________________

**Health Care Provider's Signature:**

______________________________________________________________________________

Parents/Guardians Name: (typed or printed)

______________________________________________________________________________

Address: ______________________________________________________________________

______________________________________________________________________________

Phone: (____)__________________________

**Parents/Guardians Signature:**

______________________________________________________________________________