

2007 Camp Session Dates and Locations

“Tallahassee Camp” is at Centenary Camp in Quincy, North of Tallahassee
“Cycling Camp” takes place in Central Florida, exact route to be announced
“Fun Sports Camp” and “Pee Wee Camp” are at Rotary’s Camp Florida in Brandon, East of Tampa
“Winona Session 1” and “Session 2” take place in DeLeon Springs, near Daytona Beach

Sessions for Campers 6 to 14 years old

Camp Session	Camp Dates	Application Deadline
Tallahassee Camp (ages 7-11)	Tuesday June 12 to Saturday June 16	Tuesday May 29, 2007
Pee Wee Camp (ages 6-8)	Sunday July 1 to Friday July 6	Friday June 15, 2007
Winona Session 1 (ages 12-14)	Sunday July 15 to Monday July 23	Friday June 22, 2007
Winona Session 2 (ages 9-11)	Saturday July 28 to Saturday August 4	Friday July 6, 2007

Sessions for Campers 15 to 18 years old

Camp Session	Camp Dates	Application Deadline
Cycling Camp (Central Florida)	Saturday June 16 to Thursday June 21	Friday June 8, 2007
Fun Sports Camp (Tampa)	Sunday June 24 to Friday June 29	Friday June 8, 2007

ELIGIBILITY, NOTIFICATION & ACCEPTANCE

All children with type 1 diabetes taking insulin injections or on the insulin pump are eligible to attend FCCYD. This includes youngsters who are not yet able to give their insulin independently. Children on the insulin pump must have been on the pump for at least 1 month prior to their attendance. The goal of camp is to make campers more independent in their diabetes care. Education will be provided for all levels.

Campers are accepted on a first come, first served basis. Priority will be given to campers who have not attended diabetes camp previously and campers diagnosed within the past 12 months. Because of limited space, NO places will be held for campers until the Florida Diabetes Camp Office RECEIVES the 2007 camper application and a deposit.

This application must be submitted and signed in hardcopy. **No applications accepted by E-mail or telephone. If an application is faxed, the deposit and signed originals must be mailed to our office within 10 days to hold spot.** Information and acceptance packets, including directions to camp, will be sent to you two weeks prior to your camp session. **Applications received after the deadline will be accepted at the discretion of the directors. If your application is rejected your deposit will be returned.**

CANCELLATION AND REFUND POLICY

A non-refundable deposit for camp programs is required with application (unless other prior arrangements have been made with the camp office). The deposit applies towards camp fees. Cancellations more than 30 calendar days in advance receive full refund (minus deposit); less than 30 days but more than 10 days, 50 % refund; less than 10 days, but more than 24 hours 25 % refund. NO SHOW WITHOUT 24 HOURS NOTIFICATION, NO REFUND OR CREDIT TOWARDS OTHER PROGRAMS.

Mailing Address for Applications and Business Correspondence

Florida Diabetes Camps

PO Box 14136

Gainesville, FL 32604

(This is our office mailing address DO NOT send mail to campers at this address)

Your child’s camp mailing address will be sent to you with the acceptance packet

Frank Diamond, MD, President
Janet Silverstein, MD, Medical Director
Rosalie Bandyopadhyay, Financial Aid Director
Gary Cornwell, Program Director
Katie Pagan, Medical Coordinator

Office Telephone: (352) 334-1321
Fax: (352) 334-1326
Financial Aid Assistance: (352) 334-1323
e-mail: FCCYD@floridadiabetescamp.org
Website: <http://www.floridadiabetescamp.org>

Office Use--Date Received: _____

**Florida Camp for Children and Youth with Diabetes (FCCYD)
2007 Camper Application**

Application for session (please check one):

Tallahassee Camp (Ages 7-11) _____
Winona Session 1 (Ages 12-14) _____
Fun Sports Camp (Ages 15-18) _____

Pee-Wee Camp (Ages 6-8) _____
Winona Session 2 (Ages 9-11) _____
Cycling Camp (Ages 15-18) _____

Name _____ Nickname _____
Last First Middle Initial

Address _____

City _____ State _____ Zip _____ County _____

Date of Birth ___/___/___ Age at Camp ___ Date Diagnosed (month/year): ___/___ Sex ___ Race ___

Grade next year (Fall 2007) ___ Type of Class: Gifted ___ Regular Ed. ___ Special Ed. (Specify) _____

Camper's Height: _____ Camper's Weight: _____ T-shirt Size (Please Circle) CM CL AS AM AL AXL AXXL

Has child attended Florida's Diabetes Camp before? Yes ___ No ___ List year(s) _____ Session _____

Has child attended a FCCYD weekend program? Yes ___ No ___ List year(s) _____ Place _____

Biological Mother's Name: _____ Home Phone (____) _____

Company Name _____ Occupation: _____

Mother's Cell Phone(____) _____ Mother's Work Phone (____) _____

Mother's E-mail address (print clearly) _____

Biological Father's Name: _____ Home Phone (____) _____

Company Name _____ Business Phone (____) _____ Occupation: _____

Father's Cell Phone(____) _____ Father's Work Phone (____) _____

Father's E-mail address (print clearly) _____

Step Father's Name _____ Step Mother's Name _____

Who has legal authority to sign documents for this child? _____

If other than biological or adoptive parent(s) please attach legal affidavit with this application

Are both biological parents living? ___ Married ___ Separated ___ Divorced ___ Single ___ Foster ___

With whom does the camper primarily reside? _____

Names and ages of campers' siblings and others living in the house:

Emergency Contact (PERSON NOT LIVING IN SAME HOUSEHOLD):

(____) _____
Phone Address Relationship to camper

Endocrinologist _____ Address _____

City _____ St _____ Zip _____ Telephone (____) _____

Physician or Pediatrician _____ Address _____

City _____ St _____ Zip _____ Telephone (____) _____

An adult familiar with the child must accompany him/her to camp on registration day for medical intake

THE FOLLOWING MUST BE COMPLETED FOR ATTENDANCE

This page must be completed and signed by a parent or legal guardian. Return with application. The application will not be considered complete and will be returned to you unless this page is signed, witnessed, dated, and returned to the camp office. Your child's spot will not be held until this is completed and received.

MEDICAL TREATMENT RELEASE

The information contained in this application is correct as far as I know. (Name of camper) _____
_____ has permission to engage in all prescribed camp activities.

I hereby give permission for the camp personnel to:

- a) To provide ongoing medical care, including regular blood and urine tests for sugar and acetone and make insulin dose adjustments as necessary.
- b) To select all medical personnel and order x-rays or any routine tests or treatment for the person listed above.
- c) In an emergency, the camp medical director may seek to transport, hospitalize, secure treatment for, and order injections, anesthesia and/or surgery for medical or dental problems for the person named above. I understand that every effort will be made to notify me.
- d) To share my child's medical information and camp records with their referring physicians, CMS coordinator (if applicable), emergency personnel and other care providers as deemed necessary by FCCYD staff.

"I give my permission to the Florida Camp for Children and Youth with Diabetes, Inc. and the Directors to transport and admit my child to a hospital in the event that medical attention is necessary. This may include tests, x-rays, anesthesia, and/or surgery for medical or dental problems for the camper named above. I understand that the camp will notify me of any emergency as soon as possible. I understand that the Florida Camp for Children and Youth with Diabetes is not responsible for injury that may result from accidents, illnesses or other causes."

RELEASE OF RECORDS

I hereby authorize my child's physicians, counselors, case workers and school personnel to release/share any records and information deemed pertinent to be included in the review of my child's application and participation at camp.

MEDIA RELEASE

I give my permission for any pictures or video taken during camp which include my child to be published by FCCYD and/or the communications media in any way deemed appropriate by the Directors.

Signature of parent or legal guardian _____ **Date:** _____

Witness (must be witnessed by an adult) _____ **Date:** _____

This application will be returned to you if this permission is not witnessed and dated.

BEHAVIORAL EXPECTATIONS

We are all coming to camp to have a safe, fun and enriching experience. To help meet these goals, appropriate behavior is expected of ALL campers in our care. Our expectations include:

- Following all safety and medical rules.
- Eating a balanced meal. Reasonable alternatives are provided.
- Participation in scheduled camp activities.
- Refraining from the use of abusive language, violence, or other inappropriate behavior.
- Staying with assigned group or cabin and treating other campers, counselors, and staff with respect.
- Possession and/or use of tobacco products, alcohol, any illegal substance, or medication not registered with the camp nurse are prohibited and will result in immediate expulsion and/or prosecution.

If a camper is having difficulty adhering to these expectations, they will be counseled and encouraged to modify their behaviors. If inappropriate activity continues a camper will be expected to agree to a behavioral contract and, ultimately be asked to return home if the inappropriate behavior persists. A child having difficulty adhering to these expectations risks losing the privilege of returning to camp in the future. By fulfilling these camp expectations, we foresee a cooperative and fun session.

FCCYD reserves the right not to accept applications from youngsters who after repeated attendance at camp do not meet these behavioral expectations and/or have not received counseling as recommended by FCCYD staff.

I have read this with/to my child and we understand and agree to these conditions.

Both parent AND camper MUST sign

Signature _____ Camper _____ Date _____

Signature _____ Parent _____ Date _____

CAMP HEALTH HISTORY AND EXAMINATION FORM FOR 2007

This form to be completed and signed by licensed physician

This physical exam should be completed within three months of camp and returned to the camp office two weeks PRIOR to the beginning of the child's session.

Please complete both sides of the form

Camper's Name: _____ Session _____

Birthdate ____/____/____ Date of last exam ____/____/____ Most recent HgbA1C _____ date ____/____/____

Date Diabetes Diagnosed: _____ Height _____ Weight _____ Blood pressure _____/_____/_____

INSULIN DELIVERY SYSTEM USED AT HOME: Injections/Syringe Injections/Pen Pump

INSULIN BRAND: Lilly (Humulin) Novo (Novolin) Aventis (Lantus)

INSULIN TYPE: Humalog Novolog Apidra Regular NPH Levimer(Detemir) Lantus(Glargine)
70/30 Humalog 70/30 Novolin 70/30 Novolog 75/25 Humalog

Insulin Dose (Injections): AM _____ Lunch _____ PM _____ Bedtime _____
(Please indicate dose and type of insulin **example:** 12N/3H for 12 units of NPH and 3 units of Humalog)

Carb ratio (for Levimer/Lantus) AM _____ Lunch _____ PM _____ Bedtime _____

Correction Factor/Sliding Scale: _____

Use Insulin Pump at Camp? Yes ___ No ___ (If yes, please fill out section below)

Pump Brand/Model _____ **Type of infusion set** _____

Target BG _____ **Correction Factor** _____ **Insulin Sensitivity** _____

Basal Rate: 12:00AM = _____ = _____ = _____ = _____ = _____
_____ = _____ = _____ = _____ = _____ = _____

Carb ratio AM _____ Lunch _____ PM _____ Bedtime _____

If child will remain on the pump at camp, the following adjustments should be made upon arrival:

BASAL RATE:

FOR BOLUS:

Diabetes Camp provides an extremely active program in which a large percentage of daily activities involves water sports. Because of this, insulin pump use during the camp session can be challenging and requires extra effort. Some campers may choose to not take the pump to camp and to give insulin by injection during the camp sessions. If so, camper **MUST** discontinue pump use 2 days prior to camp.

If child is going off the pump for camp, please provide the protocol for injections:

INSULIN BRAND/TYPE (eg. Lilly/Novo/Aventis - NPH, Humalog, etc):

Insulin Dose (Injections): AM _____ Lunch _____ PM _____ Bedtime _____
(Please indicate dose and type of insulin **example:** 12N/3H for 12 units of NPH and 3 units of Humalog)

**PLEASE TURN OVER – BOTH SIDES TO BE COMPLETED BY THE PHYSICIAN
FOR BOTH PUMP AND NON-PUMP USERS**

CAMP HEALTH HISTORY AND EXAMINATION FORM FOR 2007

Both sides of this form to be completed and signed by licensed physician

HEALTH HISTORY:

Medical Conditions: (e.g. asthma, heart murmur etc.) _____

Date and nature of any operations, injuries, or non-diabetes related hospitalizations:

How many Diabetes Related Visits to the ER in the last 12 months _____ List dates and Reason:
Hypoglycemia: _____ DKA: _____ Other: _____

How many Diabetes Related Hospitalizations in the last 12 months _____ List dates and Reasons:
Hypoglycemia: _____ DKA: _____ Other: _____

Any hypoglycemic seizures in the past 12 months (Y/N)? _____
If yes, what time of day did seizure occur: _____

Has child required **psychological counseling** in the past 12 months (Y/N)? _____
If yes, date and nature of care: _____

Is child currently being treated by a counselor (psychiatrist/psychologist/therapist) (Y/N)? _____
If yes, date and nature of care: _____

Has child ever been hospitalized for psychological issues (Y/N)? _____
If yes, date and reason for hospitalizations: _____

Recommendations and Restrictions while at Camp

Treatment other than diabetes management to be continued at Camp _____

Dietary Restrictions: _____

Allergies: _____ Symptoms: _____ Uses Epi Pen (Y/N)? _____

CURRENT MEDICATIONS: *Please bring all medications with you and give to camp nurse!*

RX: _____ Dose: _____ Reason: _____

RX: _____ Dose: _____ Reason: _____

RX: _____ Dose: _____ Reason: _____

The patient is physically and emotionally able to participate in an active camp program **YES / NO**

Licensed physician full name (**please print**) _____

I have further important issues to discuss about this patient, please contact me by telephone **YES / NO**

Address including suite # and zip code _____

Phone (____) _____ Date form completed _____

Physician's signature _____

If completed by nurse or PA, please sign _____

PLEASE TURN OVER – BOTH SIDES TO BE COMPLETED BY THE PHYSICIAN

Forms not signed and dated by the physician, nurse, or PA will be returned to the parent

CAMPER HEALTH HISTORY AND IMMUNIZATIONS

To be completed by parent/guardian

Camper Name _____ Date of Birth _____ Sex _____ Session _____

Give approximate dates for the following illnesses:

	Ear Infections		Dehydration/vomiting with ketones
	Heart defect/disease		Chicken Pox
	Seizures		Insect sting (allergic reactions)
	Bleeding/clotting disorders		Penicillin (allergic reactions)
	High blood pressure		Poison Ivy, etc
	Psychological counseling		Allergy to other drugs (Specify _____)
	Asthma		Other allergies (Specify _____)

Date of last physical examination _____ Physician's name _____

Dates and nature of any surgeries or injuries _____

Disability or chronic or recurring illness _____

Does your child have any behavioral/psychological problems of which we should be aware or that need to be discussed with camp personnel? _____

Has your child seen a counselor/psychologist/psychiatrist/therapist? No _____ Yes _____ Dates _____

Reason _____

Has your child ever been hospitalized for behavioral or psychiatric care? _____

If so when and why? _____

How many days of school did your child miss this year due to behavioral problems _____ or school problems _____ or diabetes _____ Please explain _____

Dietary Restrictions _____

Current medications (other than insulin). Please send enough with instructions to last the entire session. (Vitamins will not be dispensed) _____

Uses Epi Pen (Y/N)? _____ If yes, please bring Epi Pen to camp

Has your daughter started her period? Yes _____ No _____ When _____

If your daughter has not started her period, has she been told about menstruation? _____

There will be NO special concessions for those who have their period during the camp sessions. Campers are required to participate in all activities, including swimming, even if menstruating. Campers are expected to bring their own sanitary supplies.

IMMUNIZATION RECORD MUST BE COMPLETED FOR ACCEPTANCE

You may substitute a school or State of Florida immunization form. **If you are a returning camper and have previously submitted the record, you only need to list updates and boosters.** If your child has not received the additional MMR booster after the original one at age 12 - 18 months, please consult your doctor.

FCCYD Medical Staff strongly recommends that ALL campers be immunized against Hepatitis B.

***Tetanus immunization must be up to date. Please consult your doctor.**

VACCINES	YEAR OF BASIC IMMUNIZATION	YEAR OF LAST BOOSTER
DPT (Diphtheria, Pertussis/Whooping Cough, Tetanus)		
TD* (Tetanus, Diphtheria) or tetanus toxoid (Tetanus must be up to date)		*
MMR (Measles, Mump, Rubella)		
Polio		
Tuberculin Test ___ (most recent)	Results _____	
Hepatitis B		
Chicken Pox		

Please Provide FCCYD with a recent photo of the camper, preferably this year's school picture.

Child's Name _____

Session Attending _____

Age at time of photo _____

Name of School _____

School Phone _____

Current Grade _____

(Or most recently completed grade if applying for camp after the end of the school year)

Home Schooled _____

School Attendance: Days missed (absent) during the school year _____

Reason for absence _____

Please Staple or Tape Photo Here
(Please write name on back)

PLEASE ENCLOSE COPY OF CAMPER'S LATEST REPORT CARD. REQUIRED FOR ACCEPTANCE

INSURANCE: Do you carry medical/hospital insurance? Yes ___ No ___

Name of Carrier _____ Policy/group Number _____

Telephone Number of insurance company _____ Address _____

Please send a photocopy of your insurance card for our records including Medicaid or CMS Network card.

TRANSPORTATION INFORMATION

My child _____ will be brought to camp by _____.

He/she will be picked up by _____.

Each camper must proceed through INTAKE upon arrival at camp with a parent or other responsible adult who can provide medical and other data to the medical director and counselors.

Florida Camp for Children and Youth with Diabetes will NOT be responsible for meeting campers at bus stations, airports, or any other locations.

X _____
Signature of parent/guardian

DIABETES MANAGEMENT INFORMATION

A. Has your child ever required any diabetes related hospitalization other than at diagnosis?

No ___ Yes ___ Number of times in past year _____

Reason hospitalized _____

B. Blood glucose monitoring done _____ times per day, _____ times per week.

C. Does your child use an insulin pen? Yes _____ No _____

CAMPER GOALS

A) What do you want to learn at camp? _____

B) What do you most look forward to doing while at camp? _____

C) My two favorite activities are: 1) _____

2) _____

PARENTAL GOALS

What is your primary purpose in sending your child to camp? _____

PAYMENT

1. _____ FAMILY IS ASSUMING RESPONSIBILITY FOR PAYMENT OF ALL CAMP FEES.

Payment Plan available for families assuming total responsibility for child's camp fees. Follow these steps:

- Send in page 1 and page 2 of this application with a deposit (indicate amount below)
- Send in this payment page indicating your payment plan.
- Remainder of application including physical, medical form, report card, photo, etc. must be received by application deadline date for your child's session (see below)
- Full payment of fees must be made by first day of your child's camp session.
- If you will be unable to pay the full fee by first day of session please fill out financial aid (page 8) for amount you will need.

Camp Cost Registration Deadline	Make your own payment plan (Families of newly diagnosed children please call the camp office if you have missed these deadlines)
Tallahassee Camp \$400 Friday May 29, 2007	1) Deposit Amount Sent With Application \$_____ Date sent _____ By check/money order <input type="checkbox"/> or Charge to my card below <input type="checkbox"/>
Cycling Camp \$ 450 Friday June 8, 2007	2) First Payment Pledge Amount \$_____ Date to be sent _____ By check/money order <input type="checkbox"/> or Charge to my card below <input type="checkbox"/>
Pee Wee Camp \$450 Friday June 15, 2007	At least 50% camp fee should be paid by application deadline (see left column)
Sports Camp \$525 Friday June 8, 2007	
Winona I \$500 Friday June 22, 2007	3) Second Payment Amount \$_____ Date to be sent _____ By check/money order <input type="checkbox"/> or Charge to my card below <input type="checkbox"/>
Winona II \$475 Friday July 6, 2007	4) Final Payment Due at camp on 1 st day of session \$_____ By check/money order <input type="checkbox"/> or Charge to my card below <input type="checkbox"/>

Debit or Credit (Visa/MasterCard/American Express/Discover Card)

Card Number _____ - _____ - _____ - _____ Exp. Date ____/____
 Card Holder's Name _____
 Cardholder's Billing Address _____ Zip _____
 Signature _____

2. _____ SPONSORSHIPS:

FCCYD policy states that all eligible children can attend regardless of amount of fee parents can pay. However, FCCYD is a private not for profit organization not affiliated with any national charity and has limited resources. We try to ensure that all families who need aid receive some amount.

- Send the amount you can afford as a deposit with this application and fill out the next page completely.
- Total amount of the camp fee you can pay: \$_____

Families applying for financial aid from FCCYD or receiving aid from any other source must complete the financial form on back of this page. Your financial aid application will not be considered until page 8 is completed and returned.

By applying for financial assistance I/We give permission to FCCYD, Inc. to use our name and our child's name when seeking campership assistance specifically for our family (i.e.: with civic service groups in the area)
 Guardian must sign _____.

FOR FINANCIAL AID - This page must be completed by all applicants for financial aid including those children seen by the CMS Network Personnel.

Place of Employment:

Position:

Mother or _____
Father _____
Step-parent _____
Step-parent _____

Family income (amount must be included to be considered for financial assistantship)

Number of people in household _____ List names, relationship and ages of everyone in household.

Name	Relation	Age

Monthly Family Income (TOTAL FOR ALL LIVING IN HOUSEHOLD)

Must be completed by all applicants for aid including children eligible for CMS or Medicaid:

Total Salaries and Wages: \$ _____
Other Sources of Income (Disability, social security, Retirement, unemployment) \$ _____
Child Support: \$ _____
Total Monthly Family Income \$ _____

1. Is camper in foster care? **YES NO**
2. Is household eligible for food stamps? **YES NO** If YES, number _____
3. Is camper eligible for reduced school lunch program? **YES NO**
4. Is camper eligible for free school lunch program? **YES NO**
5. Is camper eligible for Medicaid? **YES NO** Medicaid # (required) _____
6. Is camper seen by Children’s Medical Services for health/medical care? **YES NO**
If so (REQUIRED) CMS Network Number _____
CMS Care Coordinator Name: _____
Care Coordinator’s phone #r with area code and extension(____) _____ Ext. _____
(Please submit a copy of your Medicaid or CMS Network Card with this application, if applicable)

Is there a special financial situation that may require our consideration?

a) _____ I already have a sponsor: _____ (sponsor name) The sponsor address is: _____ City _____ State _____ Zip _____ They have pledged \$ _____

Families are encouraged to contact service clubs and organizations such as the Lions, Kiwanis, Rotary, Hospital Auxiliaries or businesses in your area for sponsorships. We will assist in this process.

b) _____ I have applied for an American Diabetes Association (ADA) scholarship.

The ADA provides a limited number of camperships for children to attend FCCYD. Priority is given to newly diagnosed children, those who have not been to camp before, and the indigent. FCCYD and ADA are separate organizations. You must submit this camp application to FCCYD to our Gainesville office. At the same time, send your forms for a campership (financial aid from ADA) to your local ADA office. For more information and campership forms from ADA call 1-888-DIABETES (1-888-342-2383) or www.diabetes.org.

ALL APPLICATIONS MUST BE ACCOMPANIED BY A DEPOSIT

GENERAL PACKING SUGGESTIONS FOR 2007 CAMPS

Mark Camper's Name on All Personal Belongings

Packing list for your child's specific camp session will be sent two weeks before the camp starting date.

We recommend duffel bags for packing, no trunks or large suitcases as there is limited storage space

CLOTHING:

- Shorts (1 pair/day)
- 1 Pair Long pants or jeans
- T-Shirts (1 or 2 per day)
- Socks (1 or 2 pair/day)
- 2 pair shoes (sneakers are fine)
- 1 pair of flip-flops for swimming and shower
- Underwear (2 pair/day)
- Night clothes (extra for bedwetters)
- 3 or more bathing suits if possible
- Light Sweatshirt

LINENS:

- 2 sets of sheets (single bed flat and fitted)
- Plastic sheet or mattress cover for bedwetters
- Pillow and 2 pillowcases
- Light Blanket/sleeping bag optional
- 4-6 towels/ washcloths (extra towels are important)

OTHER ITEMS:

- Rain coat or poncho
- Dirty laundry bag (mark with child's name)
- Flashlight and batteries
- Sunscreen (SPF 15 or higher)
- Sun hat or visor
- Insect repellent lotion (no sprays/aerosol cans)
- Disposable camera (**put camper's name on it**)
- Small Electric Fan (Camp Winona only)

TOILETRIES:

- Toothpaste and toothbrush
- Soap (liquid soap or body wash not bar soap)
- Comb or hair brush
- Shampoo (tear free for little ones)
- Sanitary Napkins or Tampons

MEDICATIONS: Campers on insulin pump need to bring supplies for the pump (one infusion site per day AND batteries for pump) All insulin will be provided. For campers taking injections all supplies will be provided. Meters and strips for ALL campers will be supplied. If your child uses an Epi Pen, please bring that to camp with your child's name clearly marked on the pen. All other prescription medications must be brought with camper. If not you will be billed for medication.

DO NOT BRING: Any items considered dangerous (Knives, guns, weapons, or fire works)
 Alcohol, tobacco products, or any controlled substances or drugs
 Food of any kind (gum, candy, etc. even if sugar free)
 Large footlockers or trunks (there is no place to store them)
 Electronic games, CD players, tape players, radios, cell phones, pagers or two-way radios
 Money, jewelry, or expensive articles.

Please put your child's name on all items.

We recommend packing sets of clothes in separate zip-lock bags.

When you pick him/her up from camp make sure to check your child's cabin, clotheslines and lost and found.

Camp cannot afford to mail items left behind. All lost and found items are donated to charity when camp is over.

For the safety of all individuals attending camp, FCCYD personnel reserve the right to inspect all camper luggage. Inappropriate items will be held by the camp director.

CHECKLIST FOR COMPLETE APPLICATION

- Application page (page 1)
- Permission page (**must be signed by witness also**) (page 2)
- Medical Form (Doctor must complete & sign) (pages 3 & 4)
- Health History (Parent must complete) (page 5)
- Transportation, Goals, & Diabetes Management (page 6)
- Latest Report Card & Recent Photo (page 6)
- Fees & Deposit (page 7)
- Credit Card Information (page 7)
- Sponsorship and Financial Assistance Information (pages 8)