SCR PARTICIPANT DIABETIC POLICY

Each diabetic Participant MUST complete this form and Health Form online or submit hardcopy.

Participant Name: _____ **DOB:** _____ **Age:** _____ **Gender: M / F**

Year Diagnosed: _____ **Group Name:** _____

On Site Leader: _____ **Phone #** _____ **Cabin:** _____

Emergency Contact Name: _____ **Phone #** _____

Participant's Primary Dr.: _____ **Phone #** _____

Secondary Emergency Contact: _____ **Phone #** _____

Stoney Creek Ranch welcomes and accepts the diabetic participant when the following conditions are understood and agreed to by the participant. We recognize that there are limits to the type of care we can offer you. The camp Health Center is not an equipped emergency department and can only offer initial supportive care in the case of an emergency. It is our greatest desire that every participant at SCR have a safe and happy camp experience. It is with this in mind that we offer the following agreement for your consideration and signature.

____ The Participant's diabetes must be controlled and regulated with date of original diagnosis being at least 6 **months or more** from the arrival date at SCR. The Participant must be able to recognize signs and symptoms of blood glucose levels being out of safe and healthy normal range.

____ The Participant must be able to manage food intake and make adjustments in food selections from our camp menu.

____ The Participant must be responsible and able to self-manage blood glucose levels by counting carbs, monitoring blood sugars at scheduled times, and able to safely administer insulin accordingly.

____ The Participant will supply all necessary equipment (i.e.accucheck/blood glucose machine for checking blood sugars, strips for the machine, lancets, etc.), medication and snacks needed for the duration of his/her time at camp.

____ A written and signed order with parameters to follow will be provided for individuals on a sliding scale insulin regimen. The camp nurse or physician will not be held responsible for managing carb counts or insulin dosage with no exceptions. Any need for changes in insulin dosage or sliding scale must be done by written or faxed order from individual's physician.

Participant Name: _____ **DOB:** _____ **Age** _____ **Gender: M / F**

____ The Participant must wear a **neon green** arm band at all times while on camp property to be identified by staff as a diabetic.

____Out-of-camp trips must be cleared in advance with the camp director and camp Health Services Director.

____ Reasonable control of the illness must be maintained while you are a Participant. Should the Participant's condition become unstable, the Camp Director and Health Services Director will discuss the advisability of termination of the retreat experience with you. You must recognize that attending the retreat with a chronic illness such as diabetes entails certain risks for your health.

____ I acknowledge that I have read the Diabetic policy. I understand and agree to adhere to SCR guidelines in place.

Participant's Signature _____ **Date** _____