SAN JOSE PARKS, RECREATION & NEIGHBORHOOD SERVICES | CITY OF SAN JOSE CAPITAL OF SILICON VALLEY

American Diabetes Association. Project Power

Project Power
Diabetes Prevention Camp
Camper intake form 2018

Thank you for registering for the Project Power Diabetes Prevention Camp! We look forward to a fun filled, educational week with your child!

Please take a moment to tell us about your child and family. This will help us keep your child safe and create meaningful activities for the camp. This will also be helpful in determining the effectiveness of our education. Please fill out the following information and mail it or bring it into Mayfair Community Center during the parent meeting. ATTN Liz Best.

Participant information/ informacion de Participantes: **Date/Fecha:_____**

Participant's Name/ Nombre:_____
First Middle Last

Date of birth/Fecha de Nacimiento:_____ **Age/Edad** _____

Gender/Gender Identification/Género/Identificación de Género: ___ Male/Masculino ___ Female/Femenino

Identity not listed (please specify)/ Identidad no incluida (especifique): _____

Address/Dirección de Envío: _____

City/Ciudad: _____ **State/Estado**: _____ **Zip Code/Codigó Postal:** _____

Phone Number/ Número de Teléfono:_____

Participant T-shirt Size/Tamaño de blusa: Adult S Adult M Adult L Adult XL Adult XXL

Please tell us a little more about your child (favorite hobbies, sports, interests, dreams, etc.)/ Por favor díganos un poco más sobre su niño (pasatiempos favoritos, deportes, intereses, sueños, etc.)

_____

_____

PARENT / GUARDIAN QUESTIONS / PREGUNTAS PARA PADRES

Full name (First, Last)/ Nombre y Apellido: _____

Date of birth/Fecha de Nacimiento: _____ **Relationship to Child/ Relación al niño(a):** _____

Email address/Correo Electronico: _____

Primary language spoken by Parent/Guardian/ Idioma primario hablado por Padre/Guardián: _____

EMERGENCY CONTACT INFORMATION/ INFORMACION DE CONTACTO DE EMERGENCIA:

Full name (First, Last)/ Nombre y Apellido: _____

Relationship to Child/ Relación al niño (a): _____

Emergency Phone Number/ Número de Teléfono de Emergencia:_____

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GENERAL HEALTH INFORMATION FOR PARTICIPANT/ INFORMACÍON GENERAL DE SALUD PARA PARTICIPANTE

Would you say that in general your child's health is/*¿Diría usted que en general la salud de su hijo es*:
___ Excellent/*Excelente* ___ Very good/*Muy Bien* ___ Good/*Bueno* ___ Fair/*Justa* ___ Poor/*Pobre*

Has your child been diagnosed with Asthma/*¿Se le ha diagnosticado asma a su hijo?* ___ Yes/*Si* ___ No

If yes, you must send the asthma inhaler, in its original container, to the Program/*Si pusistes que si, debes enviar el inhalador de asma, en su envase original, al campamento.*

Does your child have any health condition, diagnosis or disability/*¿Su hijo tiene alguna condición de salud, diagnóstico o discapacidad?* ___ Yes/Si ___ No

If yes, please list all health conditions, diagnosis, or disabilities/*En caso afirmativo, anote todas las condiciones de salud, el diagnóstico o las discapacidades:*

_____

_____

Does your child have any allergies?/*¿Su hijo tiene Alergias?* _____

Medications (camp staff cannot administer any medication)/ Medicamentos (personal de campo no puede administrar ningún medicamento): _____

_____

Has your child been to a summer camp before?/ ¿Ha hido su hijo/a a un campamento de verano antes? ☐ Yes/Si ☐ No

Has your child received Diabetes Education before?/ ¿Ha recibido su hijo/a educación sobre la Diabetes antes?
☐ Yes/Si ☐ No Where?/¿Dónde?_____

Participant Criteria

Project Power is for children and teenagers with risk factors for developing type 2 diabetes, but not formally diagnosed with type 2 diabetes. Priority will be given to children who meet one or more of the listed criteria below: (please check any that apply)

- ☐ Overweight with BMI percentile ≥ 80-85%
- ☐ Family history of type 2 diabetes
- ☐ First degree relative with type 2 diabetes (parent or sibling)
- ☐ Diagnosis of hypertension
- ☐ Diagnosis of hyperlipidemia currently on medication or last fasting lipid panel within the past 6 months with triglycerides ≥ 200 or LDL ≥ 150
- ☐ Diagnosis of fatty liver or last liver function tests within the past 6 months with AST or ALT ≥45
- ☐ Diagnosis of polycystic ovarian syndrome
- ☐ Ethnic background at a higher risk for type 2 diabetes (i.e. African Americans, Hispanics and Native Americans)

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PHYSICAL ACTIVITY / ACTIVIDAD FÍSICA

How physically active is the participant? *(Select one)*/¿Qué tan activo es físicamente el participante? *(Seleccione uno)*

_____ no physical activity/sin actividad física **_____ minimal physical activity/actividad física mínima**

_____ some physical activity/alguna actividad física **_____ a lot of physical activity/mucha actividad física**

How many hours each day is the participant physically active? *(Select one)/* ¿Cuántas horas al día es el participante físicamente activo? *(Seleccione uno)*

_____ less than 30 minutes/menos de 30 minutos **_____ 30 minutes/30 minutos**

_____ 1 hour/1 hora **_____ 2 hours/2 horas**

_____ 3 or more hours/3 horas o mas

What (if anything) limits your participant's physical activity/ Que limita la actividad fisica de su hijo? _____

Does your child play any sports?/¿Juega algún deporte? ☐ Yes/Sí ☐ No If yes, which ones?/ Sí, ¿cuáles? _____

Do the people in your family exercise regularly?/ ¿La gente en su de familia hacen ejercicio regularmente? ☐ Yes/Si ☐ No

NUTRITION / FOOD/ NUTRICIÓN/COMIDA

On average, how many servings of fruit does your participant eat per day? *(Select one)/* En promedio, ¿cuántas porciones de fruta come su participante por día? (Seleccione uno): ___0 ___1 ___2 ___3 or more/o mas

On average, how many servings of vegetables does your participant eat per day? *(Select one)/* En promedio, ¿cuántas porciones de vegetales come su participante por día? (Seleccione uno): ___0 ___1 ___2 ___3 or more/o mas

What beverage does your participant drink most frequently*? (Select one)/*¿Qué bebida bebé más frecuentemente su participante? (Seleccione uno):

_____ Fruit Juice/Jugo _____ Water/Agua _____ Milk/Leche _____ Soda/Soda/Carbonated Beverage/bebida carbonatada

_____ Diet Soda/Refresco de dieta/Diet Carbonated Beverage/Bebidas carbonatadas de dieta

Do you know how to read a food label?/¿Sabes cómo leer una etiqueta de los alimentos? ☐ Yes/Si ☐ No

Does your child know how to read a food label? /¿Sabe su hijo a leer una etiqueta de los alimentos? ☐ Yes/Si ☐ No

When your family has a snack at home, is it healthy?/¿Cuando su familia lome en casa, es saludable?

☐ Most of the time/La mayoría del tiempo ☐ half the time/ la mitad del tiempo ☐usually not/ Usualmente no

Who does the food shopping in your family?/¿Quién hace las compras de alimentos en su familia?

☐ mom/ mamá ☐dad/ papá ☐ both parents/ ambos padres ☐ parents and kids together/ padres e hijos

☐ other family/ juntos o miembro de la familia member

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If there was one food that you wish they wouldn't eat, what would it be?/ Si hubiera un alimento que quisieras no comer, ¿qué sería? _____

DAILY LIVING / LA VIDA DIARIA

How long does the participant sleep each night? ***(Select one)/ ¿Cuánto tiempo duerme el participante cada noche? (Seleccione uno)***

_____ Less than 5 hours/Menos de 5 horas **_____ 5-6 hours/5-6 horas** **_____ 7-8 hours/7-8 horas**

_____ 9-10 hours/9-10 horas **_____ 11 + hours/11+ horas**

How many hours of screen time does the participant use each day (watching TV, using computer, video games, etc.)? *(select one)/*¿Cuántas horas de pantalla usa el participante cada día (viendo la televisión, usando la computadora, los videojuegos, etc.)? (Seleccione uno)

_____ 0-2 hours/0-2 horas **_____ 3-4 hours/3-4 horas** **_____ 5-6 hours/5-6 horas** **_____ 7-8 hours/7-8 horas**

_____ more than 8 hours/mas de 8 horas

Does the participant have a smartphone? If yes, how many hours per day are spent on their smartphone?/¿Tiene el participante un smartphone? En caso afirmativo, ¿cuántas horas diarias se gastan en su smartphone?

_____

What are the participant's favorite hobbies (how they like to spend their time)?/¿Cuáles son los pasatiempos favoritos del participante (cómo les gusta pasar su tiempo)?

_____
_____

My child struggles with/Mi hijo lucha con: *check all that apply/marque todo lo que corresponda.*

- ☐ **Making friends/Haciendo Amigos**
- ☐ **Interacting with peers/Interactuando con sus compañeros**
- ☐ **Interacting with adults/Interactuando con adultos**
- ☐ **Expressing feelings/Expresando sentimientos**
- ☐ **Participating in group activities/Participando en actividades de grupo**
- ☐ **Managing stress/Manejando el estrés**
- ☐ **Homesickness/Nostalgia**
- ☐ **Special fears/Miedos especiales**
- ☐ **Getting angry easily/Se enoja fácilmente**
- ☐ **Keeping their hands and feet to themselves /Manteniendo las manos y los pies quieto**
- ☐ **Running away/Huyendo**
- ☐ **Other/Otros: _____**

How can we help your child be successful at this program?/¿Cómo podemos ayudar a su hijo poder tener éxito en el campamento?

_____

What are <u>your</u> goals for this program?/¿Cuáles son sus metas para este programa?_____

Please mail or bring this completed form to: Mayfair Community Center
Attn: Liz Best
2039 Kammerer Ave
San Jose, CA 95116