Camp Needlepoint Scholarship Application

Applicant Information

Full Name of Applicant: _____

Date of Birth: _____

Have you attended Camp Needlepoint in the past? ☐ Yes ☐ No

If yes, what dates? _____

Parent Information

Parent(s) Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Other Phone: _____

Healthcare Information

Primary Clinic: _____ Primary Physician: _____

Date of Diagnosis with Type 1 Diabetes: _____

Signature: _____ Date: _____

Please mail completed application to:

Cuyuna Regional Medical Center
Attn: Diabetes Education
320 East Main Street
Crosby, MN 56441

For Office Use Only
Reviewed by: _____
Date: _____
Eligible: ☐ Yes ☐ No