Camp High Hopes 2005

103 Fay Rd. Syracuse, NY 13219 ph.315-463-5354
www.camphighhopes.org

CAMPER APPLICATION - camp is Aug.7th to Aug.13th

One child per form - print neatly in pen – include a recent picture of child

Name: _____ Date of Birth: _____

Home Phone: _____

Work Phone: _____

Home address _____

_____

Place photo here

_____

E-Mail: _____

Parent(s) _____ OR Guardian(s) _____

Name(s): _____

Who will bring this child to camp? _____

Who will bring this child home? _____

IN AN EMERGENCY is there someone else we can call if we can't reach you?

Name: _____ Phone: _____

Name: _____ Phone: _____

Treatment Center: _____

Shirt Size: (check one)

Youth Small ____	Adult Small ____	Adult X-Lg. ____
Youth Med. ____	Adult Med. ____	Adult 2-X ____
Youth Large ____	Adult Large ____	

** SEE RELEASE ON BACK – REMEMBER THERE ARE TWO MEDICAL FORMS **

AUTHORIZATION & RELEASE

Please read carefully; this must be signed & notarized.

I/We (parent/guardian) _____,

having legal custody of (child) _____,
give permission for this child to attend Camp High Hopes *from August 7 to August 13* at Camp Aldersgate (N.C.N.Y.C. Camping Ministries) in Brantingham, New York. We give permission for this child to participate in all camp activities. In consideration of the benefits we derive from this we expressly waive all claims against Camp High Hopes, Camp Aldersgate, the N.C.N.Y.C. Camping Ministries, their staffs and representatives, in the case of any accident/injury/illness that may occur to this child at camp.

We give permission for this child to receive treatment for their bleeding disorder or any other emergency medical need that may arise at camp. This may include the child being taken to a medical facility for treatment at the discretion of the Camp High Hopes Medical Director and without the written consent of the child's parent(s) or guardian(s). We accept full responsibility for all of the costs of such emergency and/or inpatient treatment.

We also give permission for pictures/recordings to be made of this child for Camp High Hopes to use in informing others about camp. I understand that no names of the children will be used when doing this, and that no pictures of this child will be put on the Camp High Hopes website or provided to any media organizations unless I sign a separate release form.

Signature of Parent
or Guardian _____

Signature of Parent
or Guardian _____

This day _____ came _____
known and identified to me as the person(s) who have signed here, and who have acknowledged they understand and freely agree to this.

Notary
Public: _____

Commission
Expires: _____ (notary stamp)

CAMP HIGH HOPES - 2005
Health Form-To be Completed by Parents
PLEASE RETURN FORM BY JULY 15, 2005
Date_____

Camper's Name_____ Age_____ DOB_____

Address_____ Zip Code_____

Parent or Guardian_____

Home Phone ( )_____ Work Phone ( )_____

Emergency contact: Can this individual be given medical information regarding your child? Yes or No?
(Circle one)

Name_____

Address_____

Phonenumber_____ Relationship_____

Physician's name_____
Phone_____Contact Person_____

Treatment Center _____
Phone_____Contact Person_____

Type of Clotting Disorder and percent activity: A (Factor 8)_____% B (Factor 9)_____%
Type of Von Willebrand's _____ Does your child have an inhibitor?_____

Does your child have:

	Y	N		Y	N
frequent sore throat			habits/rituals		
frequent colds			rashes		
sinus infections			sleepwalking		
stomach problems			fainting		
kidney disease			appetite loss		
heart disease			fever s		
hayfever			sun sensitivity		
asthma			bedwetting		
seizures			unique behaviors		
diabetes			homesickness		
constipation			fears/phobias		
diarrhea			loose teeth		
tubes in ears			glasses/contacts		
swimmer's ear			nosebleeds		
hickman catheter			infusaport/medport		
bad dreams			other		

If yes to any of the above, please explain_____
_____
_____

Does your child have allergies to medicine, insects or foods? _____

_____

Does your child receive allergy shots?_____

If your child is on a special diet, please describe._____

Is your child on any medications at the present time? Please list and put dosage and indications below .

Scheduled Medication	Dose	Times to be given
_____	_____	_____
_____	_____	_____
_____	_____	_____

"As Needed" Medication	Dose	Times to be given	Reason to give this medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

THE MEDICINES LISTED ABOVE, MUST ACCOMPANY YOUR CHILD TO CAMP.
ANY MEDICINE BROUGHT TO CAMP MUST BE ACCOMPANIED BY WRITTEN INSTRUCTIONS BY THE PHYSICIAN. IT WILL BE TAKEN UNDER THE DIRECTION OF THE CAMP NURSE.

Immunizations: **(MUST BE COMPLETED OR YOUR CHILD CANNOT ATTEND CAMP):**

	original dates	date of booster
Polio	_____	
DPT	_____	
Measles, mumps, rubella(MMR)	_____	
Hepatitis B vaccine	_____	
Hepatitis A vaccine	_____	
Tetanus	_____	
Chicken Pox Vaccine	_____	
Haemphilus Influenza (H. Flu)	_____	

Has your child ever had chickenpox? Yes___ No___hepatitis? Yes___ No___What type?___

Parents must notify the camp office (315) 468-3703 of any exposure to a communicable disease (measles, mumps, German measles, chickenpox) if it occurs in the three weeks prior to the opening of camp.

Are there any physical limitations or restrictions from any activities for your child?_____

_____

Does your child wear any type of splints? _____

How are these to be applied?_____

Is your child on prophylaxis?_____ **IF YES,**

PLEASE SPECIFY THE REGIMEN FOR CAMP:

BRAND NAME OF THE FACTOR CONCENTRATE _____

PLEASE RECORD THE DOSE GIVEN AND WHICH DAYS OF THE WEEK THIS IS TO BE GIVEN

Day	Dosage	Day	Dosage
Sunday	_____	Thursday	_____
Monday	_____	Friday	_____
Tuesday	_____	Saturday	_____
Wednesday	_____		

Is your child on home care?_____ Does your child do self infusion?_____
How often does your child bleed? Weekly _____ monthly_____ yearly_____
Does your child have any reactions to replacement therapy? _____
Does your child receive any medication before his treatments?_____

If your child has von Willebrand's how is Stimate used?

Type of Bleed	Dose and Frequency	Does your child also use Amicar for this bleed?
_____	_____	_____
_____	_____	_____

Is there any thing else you would like us to know about your child.

_____

_____

_____

FACTOR CONCENTRATE MAY BE PROVIDED BY THE CAMP FOR TREATMENT; HOWEVER, THE SUPPLY WILL BE LIMITED. ONE WEEK PRIOR TO THE START OF CAMP, THE CAMP HEALTH DIRECTOR WILL SEND OUT A LETTER LETTING YOU KNOW IF IT IS NECESSARY TO BRING ANY FACTOR CONCENTRATE TO CAMP WITH YOUR CHILD. IT IS NOT NECESSARY TO BRING INFUSION SUPPLIES TO CAMP. THESE WILL BE SUPPLIED FOR YOUR CHILD.

ANY CHILD WHO USES STIMATE WILL BE REQUIRED TO BRING THEIR OWN BOTTLE AND THEIR TREATMENT SHEET.

HEALTH INSURANCE INFORMATION (To be completed for all campers)

Policy Number/Policy Holder's name

BLUE CROSS/BLUE SHIELD _____

STATE AID _____

MEDICAID _____

OTHER _____

I certify that all above information is correct.

Signature of Parent/Guardian _____

Authorization for Medical Treatment of Minors -

A child may not be treated at an outside facility without your permission except in cases of a true medical emergency.
You can prepare for unexpected care your child might need while at camp and you are not able to be reached by phone which would delay treatment and create unnecessary anxious moments for your child. Have the form witnessed by an adult different from the infirmary staff who would be responsible for your child.

I authorize the Camp High Hopes infirmary staff to act on my behalf and authorized any unexpected medical, dental, surgical care or hospitalization for the child named below during the week of camp August 7 to 13, 2005.

Signature of Parent/Guardian _____

Date _____ Relationship_____

Witness_____
(name and address)

Please return this form to: Diane Groth R.N., C.P.N.P.
Camp Health Director
103 Fay Road
Syracuse, New York 13219

CAMP HIGH HOPES

Camper Health Form - 2005- To be filled out by treatment center or provider

RETURN TO: Diane Groth R.N., C.P.N.P., Camp Health Director, 103 FAY ROAD, SYRACUSE, NEW YORK 13219. THIS FORM MUST BE RETURNED BY JULY 20 ,2005.

Camper's Name_____ Age_____Treatment Center _____
Hemophilia A_____% Hemophilia B_____% vWfAg_____ Ristocetin Cofactor_____
Date and result of last inhibitor_____
Hepatitis status: HBsAg_____ HBsAb_____HepCAb_____ Total HepA Ab_____
Does patient have :
Allergies to medications including factor concentrate_____
A target joint?_____ If so, which joint?_____

Is the child on any medications? Please indicate the medication, dosage and schedule of administration.

Medication	Dose	Route	Frequency

Below are listed OTC/PRN meds that are stocked at camp. You must indicate if the camper may receive these.

Drug Name	Route	Dosage	Schedule and Indications	Health Care Provider Order	Comments
Tylenol	PO	Per label instructions by age/weight	Every 4 hours PRN pain or fever	Yes No	
Ibuprophen	PO	Per label instructions by age/weight	Every 4-6 hours PRN pain or fever	Yes No	
Robitussin	PO	Per label instructions by age/weight	Every 4 hours PRN cough or congestion	Yes No	
Benadryl	PO	Per label instructions by age/weight	Every 4 hours PRN itching or for allergy symptoms	Yes No	

Drug Name	Route	Dosage	Schedule and Indications	Health Care Provider Order	Comments
Dimetapp	PO	Per label instructions by age/weight	Every 6-8 hours PRN for nasal drainage or congestion	Yes No	
Loperamide	PO	Per label instructions by age/weight	As directed for loose stools	Yes No	

Is this child on Prophylaxis? _____
What days of the week is the child treated? (Please circle) Mon Tues Wed Thur Fri Sat Sun
What is the dose? _____
Does the child have? (Please circle) Infusaport Hickman
What strength heparin flush does the child receive? 10 units/ml 100units/ml Other_____
Do you have a protocol if the child with a venous access device has a fever? _____

Physical Exam (must be done within three months of camp)
P_____ Bp_____ Ht._____ Cm. Wt._____ Kg. Date of exam_____
Skin-
HEENT-
Lymph nodes-
Chest-
Heart-
Abdomen-
Neuro-
Musculoskeletal-
G.U.-

Treatment of bleeding episodes: (Please include Brand of medication, dosage to be given as **these are our orders for transfusion.)**
Major bleeding (head, airway)_____

Joints_____

Soft tissue_____

Renal_____

Nosebleeds_____

Doses for pre-medication if indicated_____

Is there any other information about this patient that you would like us to be aware of? Please include any pertinent psychosocial information._____
How can we reach you during the day?_____At night or weekends?_____

Signature_____MD or NP

Printed Name_____