CAMP HIGH HOPES 2017 - CAMPER HEALTH FORM

To Be Completed By Treatment Center or Provider

Please complete and return in the enclosed envelope by June 1, 2017

CAMPER NAME: _____ Age: _____

CENTER/PROVIDER: _____ Date: _____

Hemophilia A _____% Hemophilia B _____% vWfAg _____ Ristocetin Cofactor _____

Date and result of last inhibitor: _____

Hepatitis status: Labs are required only if vaccinations are incomplete.

HBsAg _____ HBsAb _____ HepCAb _____ Total HepA Ab _____

Any environmental, medication, factor, blood products, food or insect allergies? _____

If yes, please explain. _____

Target joint(s)? _____ Specify joint(s): _____

Is the child on any medications? (Indicate medication, dosage and schedule of administration.)

Medication	Dosage	Route	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

These OTC/PRN meds are stocked at camp. Please INDICATE ALL the camper may receive:

Drug name	Route	Dosage	Schedule/Indications	Can Be Given	Comments
Tylenol	PO	per label instructions age/weight	every 4 hours PRN pain or fever	yes no	
Ibuprophen	PO	per label instructions age/weight	every 4 hours PRN pain or fever	yes no	
Robitussin	PO	per label instructions age/weight	every 4 hours PRN cough or congestion	yes no	
Benadryl	PO	per label instructions age/weight	every 4 hours PRN for itching or allergy symptoms	yes no	
Dimetapp	PO	per label instructions age/weight	every 6-8 hours PRN for nasal drainage or congestion	yes no	
Loperamide	PO	per label instructions age/weight	as directed for loose stools	yes no	

Is this child on Prophylaxis? _____ Dose: _____

What day(s) is the child treated? (Please circle) **Mon Tues Wed Thurs Fri Sat Sun**

Does the child have? (Please circle) Infusaport Hickman

How often is the CVL Flushed? _____ What solution is used to flush/lock the line? _____

What size needle is used for access? Gauge: _____ Length: _____

How often is the dressing changed? _____

What is the fever protocol for the child with CVL? _____

_____

► **Physical exam** (must be done within three months of camp) Exam Date: _____

P: _____ BP: _____ Ht: _____ in/cm. Wt: _____ lbs/kg.
Skin: _____
HEENT: _____
Lymph nodes: _____
Chest: _____
Heart: _____
Abdomen: _____
Neuro: _____
Musculoskeletal: _____
G.U. _____

► **Bleeding Episode Treatment**: Specify the brand of medication and the dose to be given.
These are our infusion orders for camp. Please attach most recent treatment protocol if you have one.

Major Bleeds (head, airway): _____

Joints: _____

Soft Tissue: _____

Renal: _____

Nosebleeds: _____

Doses for pre-medications if indicated: _____

Is there anything else about this child you would like us to be aware of (including psychosocial issues)?

_____

_____

Your daytime phone: _____ Signature: _____ MD or NP

Night/Weekends: _____ Printed Name: _____

Return this form in the enclosed envelope by June 1, 2017 to: **Camp High Hopes c/o Hope Woodcock-R**
82 Pixley Road, Chenango Forks, NY 1

CAMP HIGH HOPES 2017- CAMPER HEALTH FORM

To Be Completed By Parent/Guardian

Please complete and return by June 1, 2017

Camper Name: _____ Age: _____ DOB: _____

Parent or Guardian: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____

▪ **Emergency Contact:** ***Can we give this person medical information about this child?*** Yes: ____ No: ____

Name: _____ Relationship: _____

Phone: (____) _____ Address: _____

Physician's Name: _____

Phone: (____) _____ Contact Person: _____

Treatment Center: _____

Phone: (____) _____ Contact Person: _____

Clotting Disorder & Factor Level: Factor 8: _____% Factor 9: _____% Other Factor: _____ %

Type of Von Willebrand's: _____ Does child have an inhibitor? YES: _____ NO: _____

Does your child have any of the following: Please answer "Yes" or "No" to each one:

Frequent sore throat	_____	Habits/Rituals	_____	Tubes in ears	_____
Frequents cold	_____	Rashes	_____	Glasses/contacts	_____
Sinus infections	_____	Sleepwalking	_____	Swimmer's ear	_____
Stomach problems	_____	Fainting	_____	Nose bleeds	_____
Kidney disease	_____	Appetite loss	_____	Catheter	_____
Heart disease	_____	Fevers	_____	Infusaport/Medport	_____
Hay fever	_____	Sun sensitivity	_____	Bad dreams	_____
Asthma	_____	Bedwetting	_____	Diarrhea	_____
Seizures	_____	Unique behaviors	_____	Loose teeth	_____
Diabetes	_____	Homesickness	_____	Other	_____
Constipation	_____	Fears/phobias	_____		

If yes to any of the above, please explain: _____

_____

_____

_____

Does your child have any environmental, medication, factor, blood product, insect or food allergies?

If so, please explain: _____

_____

Does your child receive allergy shots? Yes: ____ No: ____

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

_____

Is your child on any medications at this time? Yes: ___ No: ___ If yes, list medication, dosage and reason below.

Scheduled Medication:	Dose:	Times to be given:	Reason to give this medicine:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
"As Needed" Medication:	Dose:	Times to be given:	Reason to give this medicine:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

You must bring and 8 day supply of factor, needles, syringes, and any medications to camp. ALL medications must come with written instructions from the MD/NP. NY State Health Dept. regulations require all medications to be kept in the infirmary and to be taken under the supervision of the Camp Infirmary Staff.

IMMUNIZATIONS: MUST BE COMPLETED OR YOUR CHILD CAN NOT 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. flue)	_____	_____

Has your child had Chicken pox? _____ If yes, date: _____ Hepatitis? _____ If yes, what type? _____

PARENTS MUST CALL THE CAMP HEALTH DIRECTOR AT (607) 222-8412

IF THIS CHILD IS EXPOSED TO ANY COMMUNICABLE DISEASES (such as Measles, Mumps, German Measles, Chicken Pox, etc.) WITHIN 3 WEEKS OF THE START OF CAMP!

Does your child have any physical limitations or restrictions from any activities? _____

_____

_____

Has your child had any emergency room visits or hospitalizations in the past year? _____ If yes, please explain.

_____

_____

_____

Does your child wear any splints or braces? Yes: ____ No: ____

How/when are these worn? _____

_____

_____

Brand Name of FACTOR CONCENTRATE product used: _____

Please note that all Recombinant therapies may be stored at room temperature for at least three months.

Is your child on prophylaxis? Yes: _____ No: _____ Episodic: _____ Immune Tolerance: _____

Please list the dose and which days given: Sunday: _____ Monday: _____ __

Tuesday: _____ Wednesday: _____ Thursday: _____

Friday: _____ Saturday: _____

Is your child on home care? Yes ____ No ____

Does your child self- infuse? Yes ____ No ____

Who regularly administers factor at home? _____

Describe your child's bleeding episodes for the last 6 months, if any: _____

Does your child have any reactions to factor infusions? _____

_____

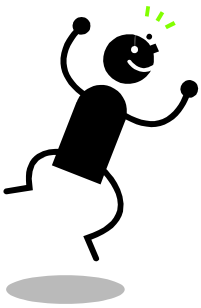
Does your child receive any medication before his treatments? _____

_____

If your child has von Willebrand's, is Stimate used? (PLEASE BRING THE TREATMENT SHEET WITH YOU)

Type of bleed:	Dose & Frequency	Does your child also use Amicar for this?
_____	_____	_____
_____	_____	_____

You will be notified by the Health Director prior to camp with your child's plan of care at camp.



We want your child to have the best possible camper experience while he is with us at Camp High Hopes.

Your answers to the following questions will help our staff to better meet their needs, and help us give your child a successful, fun-filled week!

1. Has your child ever been away from home overnight? _____
2. Has your child slept in a room with other children? _____
3. Can your child follow a structured schedule? _____
4. How many days of school did your child miss this year? _____
5. Did your child receive counseling at school this year? _____
6. Has your child ever been bullied at school? _____
7. Does your child have a 1:1 at school? _____
8. Has your child ever been involved in group activities such as team sports? _____
9. How does your child feel about taking risks/trying something new? _____
10. Does your child make new friends easily? _____

Is there anything else we should know about your child that will help us take good care of him while he is at camp?

_____

_____

_____

_____

_____

_____

_____

HEALTH INSURANCE INFORMATION

You must attach a copy of your current insurance card.

Name of Policy Holder: _____

Name of Insurance: _____

Subscriber Number: _____

Policy / Group Number: _____

* STATE AID: _____

* MEDICAID: _____

* OTHER: _____

I attest that this insurance information is correct, and that the insurance listed above is valid and covers the camper listed on this medical form. Furthermore, I agree to pay any costs not covered by this insurance which may be incurred as part of any medical treatment for this camper.

Signature of Parent/Guardian: _____ Date: _____

AUTHORIZATION & CONSENT
FOR MEDICAL TREATMENT OF A MINOR CHILD:

I, being the parent or guardian of this child, do hereby give permission to the Camp High Hopes Health Director and Medical Staff to treat this child for their bleeding disorder AND any other urgent/emergency medical need they may have during camp. This may include taking the child to an off camp medical facility at the discretion of the Camp High Hopes Health Director and without giving prior notification to the parents/guardians. Furthermore, I give permission for the Camp High Hopes Medical Staff to give medical information about this child to other medical care givers as is needed for such treatment. I accept full responsibility for all costs incurred as a result of emergency care and/or inpatient treatment.

Name(s): Please print _____

Please check one: Parents: ____ Guardians: ____ Date: _____

Signature(s): _____

Signature(s): _____

Witness: Please print _____ Date: _____

Address of Witness: _____

Signature of Witness: _____

Return this form in the enclosed envelope by June 1, 2017 to: Camp High Hopes
c/o Hope Woodcock-Ross RN, Health Director
82 Pixley Road
Chenango Forks, NY 13746

Per the New York State Camp Code updates, Section 7-2.25, effective October 2016, we are unable to accept campers who are affected by developmental disabilities judged as severe by their healthcare provider. Does this camper display mental retardation, cerebral palsy, epilepsy, autism, or neurological impairment to an extent that you would consider to be severe and likely indefinite? ____Yes _____No
(please note that Camp High Hopes will happily accept campers with disabilities who are mildly or moderately affected)

2017 CAMPER APPLICATION

Camp High Hopes

Sunday July 30 – Saturday August 5, 2017

(Please Print)

Please place a recent picture of your camper here!

Camper Name: _____ Age: _____

Address: _____

_____

_____

Parent/Guardian(s): _____

(Please circle one)

Home Phone: _____

Cell Phone(s): _____

E-Mail: _____

Date of Birth: _____

Name of person bringing your child to camp:

_____

Name of person picking up your child:

_____

Please note: If your camper is being picked up by someone other than a parent/guardian we will ask to see photo ID for the safety of your child.

EMERGENCY CONTACTS: (If we cannot reach you directly.)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Treatment Center: _____ Phone: _____

Shirt Size: **(check one)** Youth Small ____ Youth Medium ____ Youth Large ____

Adult Small ____ Adult Med. ____ Adult LG ____ Adult XL ____

Authorization & Release for Camper Attending Camp High Hopes

Please read all sections carefully before signing this release.
This release must be signed before a Notary Public.

I/We (Parent/Guardian)

_____

having legal custody of (child)

_____

1) Give permission for this child to attend Camp High Hopes *July 30 - August 5, 2017* at Camp Aldersgate (NY Methodist Camping Ministries) in Brantingham, NY and participate in all camp activities. In considerations of the benefits we receive, we expressly waive all claims against Camp High Hopes Inc., Camp Aldersgate, NY Methodist Camping Ministries, Camp Oswegatchie, and their staff/representatives in the case of any accident/injury/illness that may occur to this child at camp.
2) Give permission for this child to receive treatment for their bleeding disorder AND any other emergency/urgent medical needs that arise during camp. This may include taking the child to a hospital at the discretion of the Camp High Hopes Health Director. I accept responsibility for all costs associated with such emergency care and/or inpatient treatment.
3) Give permission for pictures/audios made of this child to publicize camp. No information identifying the child other than a first name will be used unless I sign a separate release form.
4) Accept responsibility for damage done to the property of Camp Aldersgate, Camp High Hopes, Camp Oswegatchie, or their campers/staff by this child, and agree to pay for the cost of such damage.
5) Accept that Camp Aldersgate, Camp High Hopes and Camp Oswegatchie will NOT be responsible for damage to, or loss of, any property that this child brings to camp.
6) Agree to not give/let this child bring/have at camp any Cell phones/I-phones, PDA's, Computers, Video Games, DVD Players, *or any other devices that call, message, access the internet, play movies or games, even if they play music*. This child will also not bring any caffeinated soda/drinks/food to camp.
7) **I understand and accept that if this child refuses to follow camp rules and/or cooperate with the staff of Camp High Hopes, Camp Aldersgate or Camp Oswegatchie they may be sent home. I further understand that I/we will be responsible for picking up this child in a timely manner should they be sent home.**

Signature of Parent/Guardian: _____
Signature of Parent/Guardian: _____

On this day _____ came _____
identified to me as the person(s) who have signed here, and who have acknowledged they understand and freely agree to the terms and conditions of this authorization and release.

Notary Public: _____
Commission Expires: _____ *(notary stamp)*