Share the Magic of Camp with your Family!

The Painted Turtle is now accepting application for our Spina Bifida and Paraplegia Family Weekend, November 2-4, 2012. Family Camp provides an opportunity to share good times, peer-support and education with other families. You will enjoy boating and fishing, arts and crafts, woodshop, music, and much more! And doctors and nurses are available at The Painted Turtle all weekend to take care of any medical needs families might have while at camp.

We invite you to join us at The Painted Turtle, located in Lake Hughes in the Antelope Valley, 40 miles north of Los Angeles. It's a beautiful facility with a fully equipped medical center and temperature-controlled cabins with private baths. All meals are provided and served in the dining hall overlooking the lake. The weekend fun begins at 5:00 p.m. on Friday, and ends at 11:30 a.m. on Sunday. There is no cost for families to attend this retreat!

Family Camp is for children with Spina Bifida or Paraplegia (this could include children with spinal cord injury resulting in paraplegia), ages 6-17,and their immediate family members.

Please note, the primary camper must fulfill the following criteria:

- Minimum developmental age of 5 years
- Ability to communicate needs independently
- Ability to function and participate in a group
- Can be without a family member for a limited period of time

Due to factors beyond our control (such as severe weather or low attendance), the camp session may be cancelled. In this case, all families will be notified as soon as possible.
If you are interested in attending the Family Weekend, please fill out and return the enclosed forms by **September 21, 2012.**
****Please note we CAN NOT accept applications with incomplete medical and/or immunization records****

- Family Weekend Application
- Camper Medical Information
- Camper Physician Form
- Family Medical Information
- Authorization & Release Form
- Immunization Records (for all attendees under the age of 18)
- Camper's Medical Insurance Card
- Photograph of camper

We would like to call you attention to **new vaccination requirement for the 2012-2013 flu season.**
All primary campers (child with the medical condition) must receive the seasonal flu vaccine no later than 2 weeks prior to attending the Family Weekend. Proof of the vaccination must be provided before a Welcome Packet will be sent for your camp session. Exceptions will require a note from your physician. Please call us with any questions regarding this new policy. Thank you for helping us to follow the CDC recommendations to keep camp safe for everyone.

Applications should be returned to:

Rosalyn Skelton
Camper Admissions and Database Manager
The Painted Turtle
PO Box 455
Lake Hughes CA 93532
fax: 661-724-1566
email: rosalyns@thepaintedturtle.org

Additional information may be requested for any family member with a medical condition prior to camp acceptance.

While we wish we could accommodate everyone, it is impossible to guarantee enrollment. Acceptance is based on timely receipt of the completed application in addition to medical criteria focusing on the needs of the child and our ability to provide safe and appropriate camp programming.

Campers and families will be notified by mail or email after the deadline if they have been confirmed to attend camp. The Welcome Packet will include information on what to bring, directions to The Painted Turtle and activities for the weekend.

We look forward to seeing you!

If you have any questions, please contact Camper Admissions at 661-724-1768 ext 202 or 203 or rosalyns@thepaintedturtle.org.

Dear Families,

We would like to call your attention to a **new vaccination requirement for the 2012/2013 flu season**.

All primary campers (child with the medical condition) must receive the seasonal flu vaccination prior to attending the Family Weekend. Proof of vaccination must be provided before a Welcome Packet will be sent for your camp session. The vaccination should be obtained no later than 2 weeks prior to the camp session.

Children under the age of 9 *may* require 2 doses of the vaccine. Please check with your child's physician for the appropriate vaccination schedule.

For free, or low cost immunization clinics in English and Spanish, please visit: http://www.publichealth.lacounty.gov/ip/IZclinics/clinics.htm

Exceptions will only be made for children who are medically unable to receive the vaccine, in which case, we will require a note from your child's physician.

Thank you for helping us to follow the CDC recommendations to keep camp safe for everyone. For more information, please see the CDC website www.cdc.gov/flu/

If you have any questions regarding our immunization policy, please contact Rosalyn at 661-724-1768 x203 or rosalyns@thepaintedturtle.org.

Turtle Wishes,

Rosalyn Skelton
Camper Admissions and Database Manager
The Painted Turtle

THE PAINTED TURTLE - 2012 IMMUNIZATION REQUIREMENTS

We are committed to the safety and health of all our campers, camper family members, staff and volunteers.
If you have any questions regarding immunizations, please call to speak with our camp medical staff at **661-724-1768.**

- **For family weekend sessions,** please make sure *all attendees'* immunizations are up-to-date (appropriate for age) and ***attach an official copy of the vaccination record for each child (under 18 years)* who will be attending**.
- Any missing required immunizations must be administered no later than 2 weeks before the camp session.

The following vaccines are REQUIRED:

REQUIRED Vaccine	Amount Required	Important Notes	Exceptions (If Applicable)
Seasonal Flu Vaccine	**Required for primary camper only all sessions from Oct. 15, 2012 through April 15, 2013.**	Vaccination must be administered 2 weeks prior to attending the session. Please fax proof of vaccination to camp in addition to usual vaccination record.	**Only with written exception from your child's physician.**
Measles, Mumps, Rubella (MMR)	**2 doses** MMR vaccine immunization for all campers born on or after 1957 (both must be given ON or AFTER the first birthday)		For **MMR & Varicella Vaccines:** Campers who are unable to receive live vaccines, including: transplant recipients, children receiving chemotherapy within the last year, children with a CD4 count less than 15%, children on steroids, remicade, humira, 6mp, and immuran are exempt from receiving the MMR and Varicella vaccines. **(Healthcare provider MUST indicate child is exempt on medical form provided).** Positive titers (blood test indicating immunity) to Varicella, Measles, Mumps, & Rubella are also acceptable
Varicella (Chicken Pox)	**2 doses** Varivax (Varicella) OR documented history of chicken pox disease or zoster (shingles) infections	**DO NOT ATTEND CAMP IF:** -THERE HAS BEEN CONTACT WITH A CHILD OR ADULT WITH **Chicken Pox** or **Shingles** IN THE 3 WEEKS PRIOR TO CAMP **AND/OR** -A RASH IS ACTIVELY PRESENT (within 2 weeks of vaccination) AT THE SITE OF RECENT VACCINATION	
Tetanus	Initial series of **5 DTaP shots** **The last Td/Tdap *booster must be 9.5 years or less from the beginning of the camp session*	Adacel or Boostrix vaccine (which protects against Pertussis-whooping cough) is *strongly recommended* for children 10 years of age or older who are due for a tetanus booster	
Polio	**4 shot series** required		
Hepatitis B	**3 shot series** required	2 dose series of Recombivax HB® is acceptable for children ages 11-15 years, but this must be **clearly** noted on the vaccine record	

The following vaccines are STRONGLY RECOMMENDED:

Recommended Vaccine	Amount Recommended	Important Notes
Hepatitis A	**2 shot series** for all children over 1 year of age is *strongly recommended*	
Meningococcal (Menactra) vaccine	For all children over 11 years old as well as for younger children with immunodeficiences (e.g. functional asplenia, complement deficiency)	

APPLICATIONS WILL NOT BE CONSIDERED COMPLETE, AND THEREFORE WILL NOT BE REVIEWED, UNTIL ALL IMMUNIZATION RECORDS HAVE BEEN RECEIVED. THANK YOU!

Family Camp Weekend Application

☐ Primary Immunodeficiency Diseases Family Weekend: September 28-30 ☐ Asthma and Allergy Family Weekend: October 12-14

☐ Rheumatic Diseases Family Weekend: October 26-28 ☐ Spina Bifida and Paraplegia Family Weekend: November 2-4

☐ Kidney Disease and Transplant Family Weekend: November 16-18

Camper Name _____ Date of Birth _____ Age _____ ☐ Male ☐ Female

If under 18, is child involved with DCFS (Department of Child and Family Services)? ☐ Yes ☐ No If yes, is it an open case? ☐ Yes ☐ No

Treatment Center _____ Specialist _____ Phone Number _____

Primary Diagnosis _____

Please list family members attending: **(family members include anyone living under the same roof as the camper.)**

IF UNDER 18, PLEASE ATTACH IMMUNIZATION RECORDS

Parent / Guardian Name _____ DOB _____ Relationship to camper _____

Parent / Guardian Name _____ DOB _____ Relationship to camper _____

☐ Brother ☐ Sister Name _____ Age _____ DOB _____

☐ Brother ☐ Sister Name _____ Age _____ DOB _____

☐ Brother ☐ Sister Name _____ Age _____ DOB _____

☐ Brother ☐ Sister Name _____ Age _____ DOB _____

Please note: **only immediate family members may attend camp. (family members include anyone living under the same roof as the camper.)**

☐ Other Name _____ Age _____ Relationship to camper _____

☐ Other Name _____ Age _____ Relationship to camper _____

Total number of people attending camp _____

Please list any special need required by your family. (Other than housing and food, which are provided at no charge.)

_____

Has your child previously attended a camp session at The Painted Turtle? _____ What session/years? _____

If no, have you previously applied? _____ What session/years? _____

Will your child be attending any camp other than The Painted Turtle this year? ☐ Yes ☐ No If yes, name of camp? _____

Is it a sleep-away camp? ☐ Yes ☐ No Were there any special medical accommodations made so that your child could attend camp? _____

What is your family's primary language? ☐ English ☐ Spanish ☐ Other _____

Would your family like the assistance of an interpreter while at camp? _____

Parent/Legal Guardian Contact Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone Number _____ Cell Phone Number _____

Work Phone Number _____ Email Address _____

If you need additional information or have questions regarding the application, please contact our camper admissions at (661)724-1768

Camper with Disease Condition General Medical Information *(to be completed by parent/guardian)*

Camper Name: _____ Date of Birth _____

Primary Diagnosis _____ Date of Diagnosis _____

Date of Transplant(s) (if Applicable): _____

Please list and explain any other known medical problems/conditions: (such as asthma, seizures (describe type and frequency), diabetes, ADD, incontinence, development delay, headaches, vision/hearing loss, sleep walking, etc.)

_____

Please list other major surgeries/serious injuries (dates) _____

☐ Yes ☐ No Has the above-named individual ever had a positive tuberculosis test (TB test)? If yes, provide a negative chest x-ray.

☐ Yes ☐ No Has the above-named individual ever spent time with someone with a positive TB test or someone known to have tuberculosis (TB disease)? If yes, provide a negative TB test.

Insurance Information: Campers MUST provide proof of medical insurance coverage.
You **MUST include a TWO-sided copy** of your insurance card (and a pharmacy card, if applicable).

List all Allergies ☐ None	List Allergy	Describe Reaction	If Epi-pen is required, an allergist must complete **Severe Allergy Action Plan Form**
Medication (Example: **Penicillin**) 1.			☐ Requires Epi-pen
2.			☐ Requires Epi-pen
3.			☐ Requires Epi-pen
Other (Examples: LATEX, Horses, Bee Stings) 1.			☐ Requires Epi-pen
2.			☐ Requires Epi-pen
3.			☐ Requires Epi-pen
Food (Example: Peanuts, Shellfish)-**ALLERGIES ONLY** 1.			☐ Requires Epi-pen
2.			☐ Requires Epi-pen
3.			☐ Requires Epi-pen

Has your child seen an allergist for these allergies? ☐ Yes ☐ No If yes, Name: _____ Phone: _____

List all Medications **Please attach a list of ALL medications your child takes**

_____

Special Needs

Food restrictions/Special diet (include tube feeding or TPN):

_____

Describe use of any special mobility devices (wheelchair, scooter, leg braces, crutches etc):

_____

Describe any activity restrictions:

_____

Describe any special communication needs (uses sign language, speech board, etc):

_____

Does your child have: ☐ Central Line ☐ Ostomy ☐ Gtube ☐ VP Shunt ☐ Tracheostomy ☐ Other _____

Comments _____

Health Profile In the past 12 months, your child has had how many: Hospitalizations _____

ER visits _____ Dates and reasons: _____ Dates and reasons: _____

Weekend Family Members Medical Form

The Painted Turtle needs to be prepared should your family need medical assistance while at camp. Complete this form for **all family members. Do not repeat the camper information.** All information is confidential. Each family is responsible to bring their personal medications and medical supplies.

Name of Family Member: _____ Relationship to Primary Camper _____

Date of Birth _____ Age _____ Weight _____ If under 18, is child involved with DCFS (Department of Child and Family Services)? ☐ Yes ☐ No If yes, is it an open case? ☐ Yes ☐ No

Ethnicity

☐ African-American ☐ American Indian ☐ Asian/Pacific Islander ☐ Latino ☐ White ☐ Other

The Painted Turtle is made possible through generous donations and grants from public and private organizations. Providing your ethnicity will help our prospective donors evaluate our programs. This information is for demographic purposes only, and will remain anonymous and confidential.

Does the above-named individual have any medical conditions? ☐ Yes ☐ No If yes, explain:

_____

Primary Care Physician _____ Phone Number _____

If pregnant, due date: _____ Pregnancy Care Provider _____ Phone _____

The Painted Turtle does not provide pregnancy-related medical care. Pregnant participants should expect to be sent offsite if medical care is needed and will be responsible for any related costs.

Please provide answers to immunization history questions, regardless of age. If under 18 years old, please also attach a copy of Immunization Records.

☐ Yes ☐ No Has the above -named individual received the measles, mumps, and rubella (MMR) vaccine (2-dose series)?

☐ Yes ☐ No Has the above-named individual received the varicella/chicken pox vaccine (2-dose series)?

☐ Yes ☐ No Has the above-named individual ever had chickenpox? If yes, please list date (if known): _____

☐ Yes ☐ No Has the above-named individual ever had a positive tuberculosis test (TB test)? If yes, provide a negative chest x-ray.

☐ Yes ☐ No Has the above-named individual ever spent time with someone with a positive TB test or someone known to have tuberculosis (TB disease)? If yes, provide a negative TB test.

Date of last Tetanus shot: _____

List all Allergies ☐ None

	List Allergy	Describe Reaction	If Epi-pen is required, an allergist must complete **Severe Allergy Action Plan Form**
Medication (Example: **Penicillin**) 1.			☐ Requires Epi-pen
2.			☐ Requires Epi-pen
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2.			☐ Requires Epi-pen
3.			☐ Requires Epi-pen
Food (Example: Peanuts, Shellfish)-**ALLERGIES ONLY** 1.			☐ Requires Epi-pen
2.			☐ Requires Epi-pen
3.			☐ Requires Epi-pen

Has the above-named individual seen an allergist for these allergies? ☐ Yes ☐ No If yes, Name: _____ Phone: _____

Please List all Medications ☐ None

Medication Name	Reason for Use	Medication Name	Reason for Use

Special Needs

Food restrictions/Special diet _____ ☐ None

Supportive devices (wheelchair, crutches, walker, etc) _____ ☐ None

Activity Restrictions _____ ☐ None

Weekend Family Members Medical Form

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Activity Restrictions _____ ☐ None

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Medication Name	Reason for Use	Medication Name	Reason for Use

Special Needs

Food restrictions/Special diet _____ ☐ None

Supportive devices (wheelchair, crutches, walker, etc) _____ ☐ None

Activity Restrictions _____ ☐ None

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Medication Name	Reason for Use	Medication Name	Reason for Use

Special Needs

Food restrictions/Special diet _____ ☐ None

Supportive devices (wheelchair, crutches, walker, etc) _____ ☐ None

Activity Restrictions _____ ☐ None

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_____

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Has the above-named individual seen an allergist for these allergies? ☐ Yes ☐ No If yes, Name: _____ Phone: _____

Please List all Medications ☐ None

Medication Name	Reason for Use	Medication Name	Reason for Use

Special Needs

Food restrictions/Special diet _____ ☐ None

Supportive devices (wheelchair, crutches, walker, etc) _____ ☐ None

Activity Restrictions _____ ☐ None

Confidential Campership Information

The Painted Turtle is made possible through generous donations and grants from public and private organizations. Please complete the following information, which helps our prospective donors evaluate our programs. This information is for demographic purposes only, and will remain anonymous and confidential.

Primary Camper's Ethnicity

☐ African-American ☐ American Indian ☐ Asian/Pacific Islander ☐ Latino ☐ White ☐ Other

Zip Code _____ County of Residence _____

What is the **TOTAL** number of persons residing in the home? _____

Annual Family Income: *Please check the amount closest to your family income*:

☐ $0 - $5,000 ☐ $6,000 - $8,000 ☐ $8,000 - $10,000 ☐ $10,000 - $12,000

☐ $12,000 - $15,000 ☐ $15,000 - $20,000 ☐ $20,000 - $26,000 ☐ $26,000 - $31,000

☐ $31,000 - $36,000 ☐ $36,000 - $42,000 ☐ $42,000 - $47,000 ☐ $47,000 - $53,000

☐ $53,000 - $55,000 ☐ $55,000 - $60,000 ☐ $60,000 - $65,000 ☐ over $65,000

California County and Governmental Assistance: If you and your child(ren) receive assistance, please indicate below:

☐ TANF ☐ SSI

How did you hear about The Painted Turtle?

☐ Painted Turtle Outpost ☐ Word of Mouth

☐ Clinic visit from Painted Turtle staff ☐ Internet ☐ Other _____

☐ Medical Provider ☐ Former Camper

☐ Partner Organization _____

Family Camp Weekend
Authorization & Release Form

Names of Participants (please list all family members attending):

I certify that I am the parent or legal guardian of the above named child (children) (hereinafter referred to as the "Applicant"). I understand that the Applicant(s) will be participating in many physical activities at camp, and with such knowledge I give permission for the Applicant(s) to engage in all activities except as noted by me or by my child's physician in a writing that accompanies this Form.

I authorize the camp medical staff to provide medical care to the Applicant(s) that they deem necessary, including the administration of medications unless noted below. I also authorize the Applicant(s) to receive any emergency care that is deemed advisable by the camp medical staff. I hereby give permission for The Painted Turtle staff to directly contact any of my child's physicians listed on his/her application.

I give permission to The Painted Turtle to use photographs, video footage, and statements of the Applicant(s) for promotional purposes (including but not limited to brochures, letters, posters, video, and/or the Internet) without compensation.

I hereby release The Painted Turtle, its respective employees, volunteers, directors, trustees, members and sponsors (hereinafter collectively referred to as the "Releasees") from all claims, damages and liabilities, that may result, directly or indirectly, from any injury whatsoever that the Applicant(s) may suffer while at The Painted Turtle in Lake Hughes, California or during transportation to, from or while attending Family Camp Weekend at The Painted Turtle in Lake Hughes, California.

I hereby agree to indemnify the Releasees against all claims, damages and liabilities, including legal fees and other out-of-pocket expenses, that may result, directly or indirectly, from any injury the Applicant(s) may suffer while at Family Camp Weekend or during transportation to, from or while attending Family Camp Weekend at The Painted Turtle in Lake Hughes, California.

I give permission for all Applicant(s)' medical information to be reviewed by The Painted Turtle staff and personnel to ensure the safety and wellbeing of my child while at camp.

As of January 1, 2008, The Painted Turtle is a completely non-smoking and tobacco-free camp. We do not allow alcohol, tobacco (including smokeless tobacco), or illegal drugs on the premises at any time. This includes having any of the above in your vehicle. The medical team recommends that any family members who smoke cigarettes or use tobacco products and who want to come to camp contact their own medical care providers to obtain nicotine replacement prior to the family weekend. This will help minimize any symptoms of nicotine withdrawal during your stay at camp. If, while at camp, you would like assistance with symptoms of nicotine withdrawal, then please see a member of the medical team.

The Applicant, _____, is allergic to the following medications: _____
Applicant Name

I FULLY UNDERSTAND AND AGREE TO THE TERMS STATED ABOVE AND AGREE THAT ALL INFORMATION IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

ALL ABLE ATTENDEES OVER THE AGE OF 18 MUST SIGN.

Parent/Guardian Signature (Required) Date Attendee over 18 Signature Date

Parent/Guardian/Attendee over 18 Signature Date Attendee over 18 Signature Date

Emergency Contacts

Please list ***TWO*** adults who we can contact in case of an emergency.

Full Name _____ Phone Number: _____

Full Name _____ Phone Number: _____

The Painted Turtle
Activity Permission Form & Release and Hold Harmless Agreement: Equestrian, High/Low Ropes, and Rock Climbing Wall Programs

The Painted Turtle Camp ("The Camp") provides a equestrian program, a high /low ropes program, and a rock climbing wall that offers adventurous opportunity and is supervised by professionally trained staff. All participants wear proper safety equipment provided by The Painted Turtle that is in compliance with the American Camping Association Standards. This includes helmets, harnesses and safety stirrups (horses).

All attendees may routinely participate and as common practice at The Painted Turtle Camp, all activities afforded to the attendees are optional.

In order to provide these programs, no liability can be accepted by The Camp, or any of the organizations or persons connected with The Camp. No camper will be allowed to participate in the horse, ropes, or rock climbing wall program until this form has been read, understood, and completed by the participant (if he/she is 18 years or older) or by the parent(s) or guardian(s) of a minor. Although participation in these programs is under strict supervision and every effort is made to avoid injury, accident, the undersigned acknowledged and understands the risks and potential risks associated with these programs. This includes but is not limited to: 1) The propensity of an equine to behave in a dangerous ways which may result in injury or death to the participant or damage to property: 2) The inability to predict an equine's reaction to sound, movements, objects, persons or animals; 3) Hazards of surface or subsurface conditions whether known or unknown: 4) Cuts and abrasions resulting for skin contact with the high ropes course, low ropes course, and rock climbing wall: 5) Failure to follow safety procedures set out by Equestrian Manager and equestrian staff, high/low ropes/rock climbing wall professionally trained staff and all other staff.

In consideration, for the privilege of participating in the equestrian program, high/low ropes program, and rock climbing wall the undersigned, as self, or as parent(s) or guardian(s) of the undersigned minor, jointly and severally, do hereby agree to release, defend, hold harmless and indemnify The Camp, it's officers, directors, trustees, agents, employees, representatives, successors and assigns, from all manner of liability, loss, costs, claims, demands and damages of every kind and nature whatsoever, including but not limited to reasonable attorneys' fees, which any third party, the undersigned or said minor may now or in the future have against The Camp, its officers, directors, trustees, agents, employees, instructors, volunteers, representatives, successors and assigns, on account of any accident, damage, injury, or illness, physical or mental conditions, known or unknown, to the undersigned or said minor, or the treatment thereof, arising as a result of, or in any way connected to acts or incidents occurring at or and assigns, including but not limited to their negligence or gross negligence in operating the programs described above or in any way incidental thereto.

Date: _____ **Family Name:** _____

Parent/Guardian Name (Please Print) : _____

Parent/Guardian Signature: _____

Parent/Guardian Name (Please Print) : _____

Parent/Guardian Signature: _____

Please list any additional family members (under the age of 18) you are signing for:

Name _____ Age _____ Relationship to him/her: _____

Name _____ Age _____ Relationship to him/her: _____

Name _____ Age _____ Relationship to him/her: _____

Name _____ Age _____ Relationship to him/her: _____

Name _____ Age _____ Relationship to him/her: _____

Name _____ Age _____ Relationship to him/her: _____

Severe Allergy Action Plan

For camp participants with a severe allergy, requiring use of an Epi-pen

This form must be filled out in its entirety by allergist

Place Photo Here

Name _____ Date of Birth _____

Camp Session _____

Severe allergy to: _____ **Weight (kgs)** _____

Extremely reactive to the following foods: _____

Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

Has this patient had a sudden and severe episode of anaphylaxis? ☐ Yes ☐ No

Please choose an action plan:

☐ Give epinephrine immediately at the **first sign** of **any** symptom.

☐ Give epinephrine **immediately after a known exposure** to an allergen which has caused a severe reaction in the past,(i.e. food, bee sting) **even if no symptoms are noted**.

☐ Give epinephrine **with signs or symptoms of anaphylaxis**.

☐ Other action plan: _____

Special instructions or precautions: _____

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (i.e. bronchodilator, if asthmatic): _____

Parent/Guardian Signature _____ Date _____

Physician (Allergist) Signature _____ Date _____

Physician Name _____ Specialty _____

Physician Phone _____ On Call Phone _____

This form may be faxed to: The Painted Turtle Camper Admissions 661-724-1566

Camper Medical Provider Form -Médico de campista Proveedor Forma

To Be Completed By Child's **Specialist** Provider - Ser Completado Por **médico de especialidad** (Physician/Nurse Practitioner/Physicians Assistant) Prior to Submission Of This Application **(Each page must be signed by provider)**
Please Be As Detailed As Possible And Answer All Questions. **If child routinely has lab work, please attach most recent lab results.**

Please note, the camper must fulfill the following criteria:
- Minimum developmental age of 5 years
- Ability to function and participate in a group
- Ability to communicate needs independently
- Can be without a family member for the duration of the camp session.

Today's Date

Camper Name | Date of Birth

Parent/Guardian Name | Phone Number

Primary Diagnosis
With any subclassification | Date of Diagnosis

State of Current Condition ☐ Stable ☐ Flare ☐ Medicated Remission ☐ Remission ☐ Other

RESPIRATORY
- ☐ Sleep Apnea
- ☐ Oxygen requirement
- ☐ Chronic Lung Disease
- ☐ Asthma

NEUROLOGIC
- ☐ Migraine
- ☐ Spasticity
- ☐ Severe Visual problems
- ☐ Developmental delay

INFECTIOUS DISEASE
- ☐ Recurrent GAS
- ☐ Recurrent skin infection
- ☐ Hepatitis B or C
- ☐ HIV
- ☐ TB
- ☐ Asplenia

MUSCULOSKELETAL
- ☐ Spinal fusion
- ☐ Fracture risk

OTHER
- ☐ IV or Sub Q meds
- ☐ Pregnancy

GI
- ☐ Constipation
- ☐ TPN dependent
- ☐ Eating disorder

HEMATOLOGIC
- ☐ Bleeding risk
- ☐ HAT/PVT
- ☐ BMT

IMMUNOLOGIC
- ☐ PTLD
- ☐ Acute or chronic rejection
- ☐ Autoimmune hepatitis

GENITOURINARY
- ☐ Enuresis
- ☐ Urinary incontinence
- ☐ Stool incontinence

CARDIAC
- ☐ Hypertension
- ☐ Heart Disease

ENDOCRINE
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Requires Insulin
- ☐ Growth failure

☐ Seizures Type | Duration | Date of last Seizure

Explanation

Significant past medical history/other medical conditions:

☐ Yes ☐ No Is the child developmentally appropriate for his/her age? If no, at what (approximate) age does child function?

List any communication problems, pertinent psychosocial information, or behavioral problems that would affect the child's participation in a group:

Major Surgeries & Dates (e.g. transplants)

☐ Yes ☐ No Has the child been hospitalized in the last 6 months? If yes, diagnosis.

Please include a copy of the child's discharge summary and most recent clinic note.

Infection Control-These questions MUST be answered:

☐ Yes ☐ No **Live vaccines deferred?** **If yes, explain why:**

☐ Yes ☐ No **Has the child ever had chicken pox or shingles?** ☐ Unknown Year of infection

Are you aware of any positive history for:

☐ Yes ☐ No **HA-MRSA** If yes, date cleared

☐ Yes ☐ No **VRE** If yes, date cleared

We cannot accept these campers unless infection has been cleared

☐ Yes ☐ No Has the child had any infections in the past 6 months? If yes, diagnosis.

Physician's Signature | Date

Camper Name _____ Date of Birth _____

Devices

☐ Yes ☐ No Central venous line/ Port-a-cath Type _____ Location _____

If yes, please complete CV Catheter Form.

☐ Yes ☐ No Tracheostomy Type/Size _____ Date of last change _____

☐ Apnea/O_2 Monitor
☐ CPAP/BiPAP
☐ Ventilator
☐ Oxygen
☐ VP Shunt

☐ Insulin Pump
☐ G-tube
☐ NG-tube

☐ Bile Tube
☐ Ostomy
☐ J-Pouch

☐ PE Tubes
☐ Hearing Aids
☐ Glasses/Contacts

☐ Malone / ACE
☐ Urinary Diversion, (Mitrofanoff)

If yes, name of Neurosurgeon: _____ Phone Number: _____

Bladder/Bowel Treatment Program: ☐ Yes ☐ No Prescribed bladder/bowel management program?

☐ Needs urinary catheterization Cath Size: _____ Every: _____ hours Times: _____

Size of catheterization ☐ Mitrofanoff ☐ Urethra Needs to cath at night ☐ Yes ☐ No

Level of assistance required ☐ **Independent** ☐ **Needs Supervision** ☐ **Requires Cathing by Staff**

☐ Malone/ ACE ACE irrigation _____ times a day with _____ cc Normal Saline

Level of assistance required ☐ **Independent** ☐ **Needs Supervision** ☐ **Requires Irrigation by Staff**

Any Additional Instructions: _____

List all Allergies ☐ None	List Allergy	Describe Reaction	If Epi-pen is required, please complete **Severe Allergy Action Plan Form**
Medication (Example: **Penicillin**) 1.			☐ Requires Epi-pen
2.			☐ Requires Epi-pen
3.			☐ Requires Epi-pen
Other (Examples: LATEX, Horses, Bee Stings) 1.			☐ Requires Epi-pen
2.			☐ Requires Epi-pen
3.			☐ Requires Epi-pen
Food (Example: Peanuts, Shellfish)-**ALLERGIES ONLY** 1.			☐ Requires Epi-pen
2.			☐ Requires Epi-pen
3.			☐ Requires Epi-pen

List Current Medications or attach typed medication sheet

Does the child have:

☐ Yes ☐ No Food Restrictions/Special Diet: If yes, please explain _____

☐ Yes ☐ No Special Mobility Needs (e.g. wheelchair, walker, leg braces, etc.): If yes, please explain _____

☐ Yes ☐ No Special Infection Control Precaution : If yes, please explain _____

Physician's Signature _____ Date _____

Camper Name _____ Date of Birth _____ Exam Date _____

Physical Exam: These questions must be answered

Height (inch/cm) _____ Weight **KG** _____ BP _____ HR _____

Please check if normal or give details of abnormalities below.

Head: ☐ Normal ☐ VP Shunt ☐ Other _____

Eyes: ☐ Normal ☐ Nystagmus ☐ Strabismus ☐ Amblyopia ☐ Decreased Vision ☐ Other _____

Ears: ☐ Normal ☐ PE Tubes ☐ Abnormal Hearing ☐ Cochlear Implant ☐ Other _____

Nose/Mouth: ☐ Normal ☐ Significant congestion/Rhinorrhea ☐ Oral Sores ☐ Other _____

Teeth: ☐ Normal ☐ Orthodontia ☐ Caries ☐ Gum Disease ☐ Other _____

Neck: ☐ Normal ☐ Trach ☐ Atlantoaxial Instability ☐ Abnormal Nodes ☐ Other _____

Chest: ☐ Normal ☐ Chest Wall Abnormality ☐ Wheezing ☐ Other _____

Heart: ☐ Normal ☐ Murmur ☐ Arrythmia ☐ Other _____

Abdomen: ☐ Normal ☐ Urinary Diversion ☐ Ostomy ☐ G-tube

☐ Palpable Liver/Spleen _____ cm below costal margin ☐ Other _____

Genitalia & Rectum: ☐ Normal ☐ Perianal Fissure/Tag ☐ Hemorrhoids ☐ Other _____

Neurological: ☐ Normal ☐ Paraplegia ☐ Spasticity ☐ Other _____

Musculo-skeletal: ☐ Normal ☐ Amputation(s) ☐ Weakness ☐ Contractures ☐ Other _____

Skin: ☐ Normal ☐ Decubiti ☐ Petechiae ☐ Excessive Bruising ☐ Burns ☐ Eczema ☐ Psoriasis ☐ Scarring

☐ Other _____

Back: ☐ Normal ☐ Spina Bifida ☐ Scoliosis ☐ Kyphosis ☐ Other _____

Please explain abnormalities noted above:

_____

Physician/Medical Provider's Statement: I have examined _____ and find him/her physically able to attend camp.

Comments _____

I have reviewed the camper's medical information and camp application with the child's physician/NP/PA. He/she has given approval of all the information and recommendations reported on these camp medical forms and has given me permission to sign this form on his/her behalf.

Signature _____ Print Name _____ Date _____

If completed by a nurse: As the RN working with _____ ☐ MD ☐ NP ☐ PA

Clinic Name _____ Hospital Affiliation _____ Phone Number _____

Fax Number _____ Emergency/On Call Phone _____ E-mail _____

PHYSICIAN CLEARANCE FOR ACTIVITIES

NOTE: This form must be signed by Camper's physician. Please fax to: 661-724-1566.

Camper Name: _____ Session: _____ Date: _____

Is Camper Cleared for this activity? Please check Yes or No below:

☐Yes ☐No **Horseback Riding (**Horses maintain a walking pace at all times.**)**

- Riding takes place on ½ mile trail or in the riding arena with side walkers at both locations.
- North American Riding for the Handicapped Association (NARHA) guidelines are strictly followed.
- Infection control measures are in place to protect campers with compromised immune systems.
- BLS certified medical personnel are present at all sessions.
- Restricted from riding (but may participate in horse painting and grooming):
  - Rods after spinal fusion
  - Taking anticoagulant medications or significant thrombocytopenia
  - Seizure within the past 6 months
  - Poor head control
- Camper weight restrictions may apply (generally if >200 lbs).

☐ Yes ☐No **Swimming**

- All swimming activities take place in a heated, chlorinated pool.
- There is adult and lifeguard supervision of campers in the pool area at all times.
- Restricted for campers with stool incontinence.
- Central line care as per separate form (see Specialty Clearances for Campers)

☐ Yes ☐ No **High Ropes Course and Climbing Wall**

- Course is run only with trained professionals, with BLS certified medical personnel present at all sessions.
- All campers are required to wear helmet and waist harness. Chest harness is used, in addition, if camper has low truncal tone. Campers in wheelchairs are encouraged to participate!
- Restricted from Ropes Course if:
  - Cervical spine instability -
  - Taking anticoagulant medications or significant thrombocytopenia
- Restrictions may apply for campers with tracheostomy or seizure disorder.
- Climbing wall for campers ages 14 and above.

☐ Yes ☐ No **Organic Gardening**

- There will be no digging activities for campers with compromised immune systems.
- No pesticides are used

Special care recommendations: _____

For any questions or special considerations, please call Dr. Gina Jansheski at 661-724-1768.

Physician Signature: _____ Printed Name: _____ Date: _____

Specialty: _____ Phone Number: _____ **NOTE: Camper's name must be on form.**

Specialty Clearances for Campers

NOTE: This clearance is required to attend camp if child has a central line, cardiac and/or respiratory conditions.

TO BE COMPLETED BY HEALTH CARE PROVIDER (PHYSICIAN /NURSE)

Central Venous Catheter Form

Instructions for Catheter Care
Fill out this section ONLY if this child has a central line (i.e. Hickman, Broviac, Portacath, PICC)

Type of Catheter (Single /Double Lumen; Hickman, Boviac, Groshong, PICC, Portacath) _____ Date it was inserted _____

Specific instructions for Catheter care: _____

How often is it flushed with Heparin? _____ Amount & Strength of Heparin? _____

How often is dressing changed? _____ When is cap changed? (Days of week) _____

Special Instructions:

_____

All necessary supplies (dressing kits, heparin, syringes, access needles, EMLA, etc.)must be sent to Camp with each child. Children will need 7 dressing kits (or equivalent supplies) if they plan on swimming every day.

CENTRAL LINE CONSENT - Unless otherwise specified, all children will be permitted to swim.

This child: ☐ DOES ☐ DOES NOT have permission to go swimming in a chlorine -treated swimming pool.
(Dressings will be changed immediately following swimming)

Physician's Signature _____ Date _____

Cardiac/Respiratory Clearance

Fill out this section ONLY if this child has a cardiac and/or respiratory condition

The Painted Turtle is located at 3240 ft. above sea level, which may affect some campers with cardiac or pulmonary conditions. We ask that these campers receive clearance from their specialists, as below:

1) Cardiac Clearance - if a camper has a cardiac condition, please have the cardiologist give clearance for activities.
2) Pulmonary Clearance - if a camper has need for oxygen, BiPAP or CPAP, and/or tracheostomy, please obtain clearance from pulmonology specialist.
   We must have orders for:
   a. Amount of oxygen needed and when
   b. Settings for BiPAP, CPAP or ventilator
   c. If and when pulse ox monitoring is necessary
   d. Notation regarding camper's risk if equipment is dislodged overnight

If you have any questions regarding these clearances, please feel free to call Dr. Gina Jansheski at 661-724-1768 ext 200.