A retreat for children with life-threatening illnesses and their families

Family Application

Fanconi Anemia Program August 10 – 15, 2012

Please complete and return this application to the Camp Sunshine office.

Pages 1 - 3 – Parents' forms to be completed Pages 4 - 6 – Medical forms to be completed

Application Review Policy: Every question must be answered; incomplete applications cannot be reviewed. **Do not separate the pages of this application**. Please print clearly using black or blue ink.

Patient's last name _____ **Patient's first name** _____

Name as you would like it to appear on child's nametag _____

Gender ❑ Male ❑ Female Date of Birth ____/____/____

Address _____ Apt _____ City _____ State _____ Zip _____

Home telephone_____ E-mail _____

Diagnosis _____ Date of Diagnosis ____/____/____

Treatment Center _____

Address _____ City _____ State _____ Zip_____

Physician (Specialist) _____ Telephone _____ Fax _____

Social Worker _____ Telephone _____ Fax _____

Health Insurance Company _____ Telephone _____

Policy Holder _____ Policy No. _____ Group No. _____

Date of Arrival: ____/____/____ **Date of Departure: ____/____/____**

Note: FARF-scheduled activities will begin Friday, Aug. 10 and conclude the evening of Monday, Aug. 13. Psychosocial sessions and scheduled Camp activities will continue for FA Families until Wednesday morning, Aug. 15. FARF has reserved a number of accommodations for families at nearby Point Sebago Resort for Friday (Aug 10th) through check out on Tuesday (Aug 14th) morning. In the event that you are staying at Point Sebago and wish to avail yourselves of the rest of the Camp Sunshine program, you will need to relocate to Camp Sunshine on the morning of the 14th.

Is your family is willing to share a room on the Camp Sunshine campus? _____ Yes _____ No

Is your family willing to stay at Point Sebago? _____ Yes _____ No

Prior Attendance – This is our (please circle one) 1st time 2nd time 3rd time 4th time ____th time at Camp.

How did you hear about Camp Sunshine? _____

FOR OFFICE USE ONLY

****

ACA forms sent: ___/___/___ Received: ___/___/___

Acceptance packet sent: ___/___/___ Registration Received: ___/___/___

Need for 1:1 Supervision: Yes Wheelchair: Yes Transportation needs: Yes Please specify: _____

Called Parent/Guardian: Contact Date ___/___/___ spoke with _____ (initials ____)

Contact Date ___/___/___ spoke with _____ (initials ____)

FAMILY INFORMATION

Name of parent(s) or guardian(s) child lives with: _____

Parent/Guardian 1 _____
Relationship _____
Date of Birth ___/___/___
Address _____
City, State, Zip _____
Home Phone _____
Employer _____
Work Phone _____
E-mail _____
Cellular phone _____

Parent/Guardian 2: _____
Relationship _____
Date of Birth ___/___/___
Address _____
City, State, Zip _____
Home Phone _____
Employer _____
Work Phone _____
E-mail _____
Cellular phone _____

Emergency Contact (someone who will not be attending Camp with you)

Name _____ Relationship_____ Telephone _____

Please list all immediate family members (mother, father, siblings) who will accompany the patient to Camp. (One additional support person may accompany a single parent or a parent whose partner cannot attend.) If any other family member is under the care of a physician or mental health professional, please indicate the nature of the problem.

Parent's or Legal Guardian's Name*	**Relationship & age at the time of Camp**	**Medical or Emotional problem? If "Yes," please explain**
1. _____	(_____) ____ yr	❑ No ❑ Yes _____
2. _____	(_____) ____ yr	❑ No ❑ Yes _____
Sibling's Name		
1. _____	(_____) ____ yr	❑ No ❑ Yes _____
2. _____	(_____) ____ yr	❑ No ❑ Yes _____
3. _____	(_____) ____ yr	❑ No ❑ Yes _____
4. _____	(_____) ____ yr	❑ No ❑ Yes _____
5. _____	(_____) ____ yr	❑ No ❑ Yes _____
6. _____	(_____) ____ yr	❑ No ❑ Yes _____

***IF A LEGAL GUARDIAN WILL BE ACCOMPANYING A CHILD TO CAMP, NOTARIZED DOCUMENTATION CONFIRMING THE GUARDIANSHIP MUST BE INCLUDED WITH THIS APPLICATION. WE WILL ALSO REQUIRE ORIGINAL NOTARIZED DOCUMENTATION UPON YOUR ARRIVAL.**

YOUR CHILD'S GENERAL MEDICAL HISTORY

PLEASE LIST ALL SPECIAL NEEDS SO THAT NECESSARY PREPARATIONS CAN BE MADE.
THE MORE INFORMATION WE HAVE, THE BETTER WE WILL BE ABLE TO CARE FOR YOUR CHILD.

Primary language: _____
Additional medical problems (such as asthma, diabetes, etc.): _____
Drug allergies: _____
Dietary restrictions or food allergies: _____
Physical limitations: _____
Mobility (e.g., wheelchair, crutches, amputations): _____
Special needs/care requirements (vision/hearing loss): _____
Does your child have seizures? ❑ Yes ❑ No If so, how frequently do they occur? _____
Please describe the type of seizure: _____
What treatment is necessary for the seizures? _____ When was the last seizure? _____
Is your child incontinent? ❑ Yes ❑ No If yes: ❑ Bladder ❑ Bowel Is catheterization needed? ❑ Yes ❑ No
Please provide any additional information to help us care for your child: _____
_____

Permission to use photographs, video tape and/or audio tape of you and/or your family

On behalf of myself and my family, I do hereby give Camp Sunshine, without consideration or compensation, permission to use photographs, videotape, and/or audiotape that may be taken or recorded while my child and family are attending Camp for promotional, educational, or fundraising activities. It is my understanding that these likenesses may be used to promote public and professional understanding and support of the program. I waive any right that I may have to inspect or approve the finished product or the use to which it may be applied.

Parent/Guardian/Other Adult _____ Signature _____ Date _____
(please print)

Parent/Guardian/Other Adult _____ Signature _____ Date _____
(please print)

Permission to use family name in connection with fundraising efforts

I give my permission for Camp Sunshine to use my/my family's name to help raise funds to support the Camp Sunshine program. I understand that I am to receive no compensation for the use of my/my family's name for these purposes.

Parent/Guardian/Other Adult _____ Signature _____ Date _____
(please print)

Parent/Guardian/Other Adult _____ Signature _____ Date _____
(please print)

AUTHORIZATION FOR CAMP SUNSHINE TO PROVIDE MEDICAL TREATMENT

I hereby give my consent for Camp Sunshine's medical personnel to provide any and all reasonable and necessary medical treatment for my children. I understand and consent that I am responsible for all medical expenses incurred by Camp Sunshine on my behalf or on behalf of any members of my family.

(Please include all of the children in your family who will be attending Camp Sunshine).

Children's Names	Date of Birth
1.	
2.	
3.	
4.	
5.	
6.	
7.	

This authorization shall remain in effect while we are attending Camp Sunshine at Sebago Lake in Casco, Maine.

Parent/Guardian/Other Adult _____ Signature _____ Date _____
(please print)

Parent/Guardian/Other Adult _____ Signature _____ Date _____
(please print)

I understand and agree that information disclosed regarding any of the individuals named in this application and related documents may be disclosed or otherwise released to appropriate organizations or individuals (including, but not limited to: members of the Camp Sunshine staff, insurance companies, and physicians) in connection with attendance at Camp Sunshine at Sebago Lake, Inc. I hereby confirm that the above information is true and accurate and that once accepted, I agree to update this information as you may request.

Parent/Guardian/Other Adult _____ Signature _____ Date _____
(please print)

Parent/Guardian/Other Adult _____ Signature _____ Date _____
(please print)

The patient's portion of the Camp Sunshine application and physical examination form must be sent in together. Updated laboratory studies and status report will be required 1-3 weeks prior to the Camp session.

Physicians' Guidelines for Camp Sunshine

The medical guidelines for patients who wish to attend Camp Sunshine are as follow:

1. Children are considered medically acceptable to participate in the program if they can be expected to be in good general health at the time of the camp session. We regret that we cannot accommodate patients with renal disease who are on hemodialysis. Children should not attend camp if they are entering into an anticipated period of significant myelosuppression.

2. Children should undergo laboratory testing, when appropriate, prior to attending camp. The "Late Changes" form is to be sent to camp 1-3 weeks in advance of the child's attendance.

3. The Physical Examination form must be completed by the child's subspecialist and returned along with the child's application.

4. Children should not require any therapy during Camp other than treatment usually administered by parents, with the exception of methotrexate or colony stimulating factors.

5. Children should not require any form of special medical care during the week of Camp, e.g. transfusions.

6. Arrangements for laboratory investigations at Camp should be made in advance by the referring physician, or by the parents with the camp physician upon arrival.

7. **Children or other susceptible family members who have been exposed to varicella (chickenpox) within three weeks of a camp session cannot attend. In the event that a child or family member has been exposed to shingles (herpes zoster), please contact Camp for further guidance.**

8. **Children or family members who have received oral polio vaccine within six weeks of a camp session cannot attend.**

9. Children must be 18 years of age or younger.

If a child does not meet these guidelines, please contact the Camp Sunshine office directly so the situation can be further assessed.

It is the intent of Camp Sunshine to provide a respite experience for seriously ill children and their families with as little medical intervention as possible. A physician will be present at Camp to provide evaluation of acute problems. Other than simple first aid and stabilization of acutely ill campers, however, no treatment will be offered at Camp. Transportation will be provided to a nearby medical facility in the event that other treatment is necessary. It is not the intent of Camp Sunshine to provide routine medical care for other family members.

Thank you for helping us to provide a special respite experience for your patients and their families. It is our expectation that children will be qualified as acceptable for referral by their own treating physicians with the above specifications in mind. Children who do not meet the above guidelines will find it inconvenient to receive needed medical care in this setting and should not be encouraged to attend. Please contact the Family Coordinator with any questions regarding the above or any aspect of medical support available for camp participants at 207-655-3800 between 8:30am and 4:30pm Monday through Friday.

Please remit fully completed application to:
Camp Sunshine
35 Acadia Road
Casco, ME 04015

Phone: (207) 655-3800 Fax: (207) 655-3825
e-mail: info@campsunshine.org
http://www.campsunshine.org

CAMP SUNSHINE FANCONI ANEMIA PHYSICAL EXAMINATION FORM

The following information should be provided by the pediatric hematologist/oncologist treating the child.

Please return to Camp Sunshine, 35 Acadia Road, Casco, Maine 04015
Telephone (207) 655-3800 Fax (207) 655-3825 E-mail info@campsunshine.org

THIS APPLICATION CANNOT BE PROCESSED UNTIL *ALL* THE INFORMATION BELOW IS COMPLETE.

Child's Name _____ **Date of Examination:** ____/____/____

Diagnosis: _____ **Date of Diagnosis:** ____/____/____

Allergies: _____

❶ Fanconi anemia

Is the child on active treatment? ❑ Yes Dates and nature of most recent therapy: _____

❑ No Date therapy completed: ____/____/____

Describe any recent admissions or serious illnesses: _____

List of surgeries: _____

Has the child been under the care of a psychiatrist? ❑ Yes ❑ No Please describe any behavioral, social, emotional, or psychiatric issues that may affect the child: _____

❷ Central venous access

Type of access: ❑ External (Broviac/Hickman) ❑ Internal (Portacath/Infusaport/Mediport) ❑ Not applicable

Special instructions regarding central line/port: _____

❸ Water Activities/Contact Sports

Are there any restrictions or suggestions for this child (contact sports, etc.)? _____

_____

Describe any disability or physical limitations affecting other camp activity: _____

Can the child swim in a chlorinated indoor pool? ❑ Yes ❑ No

Can the child swim in lake water? ❑ Yes ❑ No

❹ Transfusions

Is the child on a transfusion protocol? ❑ Yes ❑ No Is the child likely to require transfusion during camp? ❑ Yes ❑ No

Has the child ever had a transfusion reaction? ❑ Yes ❑ No Transfusion history of note _____

What are guidelines for transfusion? _____

What preparation or pre-medication is required? _____

❺ Bone marrow/Stem cell transplantation

Has the child undergone bone marrow/stem cell transplantation? ❑ Yes ❑ No If yes: ❑ autologous ❑ allogeneic

Date of transplant ____/____/____ Have there been any complications related to the transplant? _____

_____

❻ Varicella (If the following information is not complete, this application cannot be reviewed.)
Please indicate:

_____ (1) This child is **IMMUNE** to varicella by reason of (check one or more):

❑ clinical disease ❑ positive titer ❑ Varivax vaccine **– OR –**

_____ (2) This child is **NOT IMMUNE** to varicella and the vaccine has not been administered to him/her.

IN THE EVENT OF A VARICELLA EXPOSURE AT CAMP, WILL THIS CHILD REQUIRE IVIG AND/OR ACYCLOVIR? ❑ YES ❑ NO

❼ PHYSICAL EXAMINATION

Height:_____ Weight: _____ Pulse: _____ Respirations: _____ BP: _____/_____

Please note all abnormal findings. Check "√" indicates normal.

HEENT _____ Musculoskeletal/Back _____

Neck _____ Genitalia _____

Lungs _____ Neurologic _____

Heart _____ Skin _____

Abdomen _____ Prostheses? _____

Comments: _____

❽ LABORATORY INVESTIGATIONS

Date: _____ H/H _____/_____ WBC _____ (ANC _____) Platelets _____

Chemistries: _____ Urinalysis:_____

Will the child require laboratory tests while at camp? If so, please specify which tests and to whom results should be called/forwarded. (Please limit these to essential studies.) _____

❾ MEDICATIONS*

WITH THE EXCEPTION OF WEEKLY METHOTREXATE, CHEMOTHERAPY IS NOT ADMINISTERED AT CAMP.

Please list medications that the child receives routinely (include pain management). Attach additional pages if necessary.

Medication	Dose	Route	Frequency

*Each family should bring all medications, catheter dressings, and other supplies necessary for their child while at camp.

☞ **IS THERE ANYTHING ELSE WE SHOULD KNOW THAT WOULD BETTER ASSIST US IN PREPARING FOR THIS FAMILY TO ATTEND CAMP? IN PARTICULAR, ARE THERE ANY SOCIAL OR EMOTIONAL ISSUES PERTAINING TO ANY FAMILY MEMBER? _____**

_____

We regret that applications cannot be reviewed unless the signature of the attending hematology-oncology physician or certified oncology nurse practitioner is provided below. Thank you for your cooperation!

I have examined _____ who is physically able to engage in camp activities except for the limitations and restrictions noted above.

Attending physician's/nurse practitioner's signature: _____ Date _____
Type/print name: _____
Address: _____
Telephone: (_____) _____ Fax: (_____) _____
Telephone or pager where a physician who is familiar with child can be contacted at night and on weekends: (_____) _____

☞ **PLEASE NOTIFY US OF ANY LAST-MINUTE CHANGES (I.E., MEDICATIONS, LABORATORY RESULTS).** ☜