

CAMP BURTON SICKLE CELL CAMP APPLICATION LEADER IN TRAINING PROGRAM

August 11-14, 2017
Ages 16 - 17

Child's Name: _____ Age: _____ Birth Date: _____ Sex (M or F): _____

Parent's (Guardian's) Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Alternate Phone: _____

Email Address: _____

Child's Physician: _____ Phone: _____

Hospital: _____

EMERGENCY NOTIFICATION:

Person to be contacted in case of emergency if parent is unavailable:

Name: _____ Relationship: _____

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

Home Phone: _____ Work Phone: _____

MAIL APPLICATION before 6/01/17 to:

NW Sickle Cell Summer Camp
Attn: Trinna Bloomquist
Hematology Clinic
PO Box 5299 MS/311-1-OC
Tacoma, WA 98415
(253) 403-1169 work
(253) 403 4979 fax

**** IMPORTANT - ALL INFORMATION MUST BE PROVIDED ****

CAMP BURTON SICKLE CELL CAMP APPLICATION

August 11-14, 2017

SICKLE CELL CAMP CONSENT FORM

I give consent for my child, _____, to attend Camp Burton from August 11-14, 2017. I understand that activities in which my child might participate include, but are not limited to, boating, arts and crafts, group sports, archery, hikes and field trips out of camp.

I do hereby authorize taking of pictures, videos, motion pictures, and/or television pictures of my child, during his/her stay at the Sickle Cell Camp to be held at Camp Burton, and consent to the use of any or all pictures in publication media.

I give consent for all written materials, such as poems or expressions in writing by my child, to be used for publicity purposes by the Sickle Cell Summer Camp, and participating hospitals.

I understand that reasonable measures will be taken to safeguard the health and safety of campers and that I will be notified as soon as possible in case of an emergency. However, in the event of illness or accident, I will not hold the Camp Staff, Sickle Cell Camp or the Charles Drew Sickle Cell Board responsible.

Please check the appropriate box:

I consent to my child participating in all activities of the camp.

I consent to my child participating in all activities of the camp except as noted below:

Parent or Guardian Signature: _____ Date: _____

****** PLEASE RETURN THIS FORM WITH YOUR CAMP APPLICATION ******

SICKLE CELL HEALTH HISTORY FORM

Camper's Name: _____ Age: _____ Sex: _____

Medical Insurance /DSHS: _____ Policy #/Medicaid #: _____

If blood tests or other procedures are done while your child is at camp, local hospital requires a copy of your Medical Number and Insurance form or a copy of both sides of your card. A COPY MUST BE ENCLOSED WITH THE APPLICATION.

Diagnosis: _____

Allergies being treated for now or recently (i.e., drugs, foods, insect bites, surgery or hospitalization)

Dietary Restrictions (if any): _____

Other medical problems (i.e., asthma, hay fever, diabetes, seizures, etc.):

Please list reasons for Surgery or hospitalizations:

Please list any physical restrictions or limitation to activity (i.e., no contact sports, etc.):

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR -- PLEASE SIGN BELOW

We, the undersigned parent(s) or guardian(s) of _____ a minor, do hereby authorize the Camp Medical Staff as agents for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under, the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act or to consent to any x-ray examination, anesthetic dental or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any Dentist licensed under the provisions of the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital or otherwise.

I understand that reasonable measures will be taken to safeguard the health and safety of campers and that I will be notified as soon as possible in case of an emergency. However, in the event of illness or accident, I will not hold the Camp Staff or the sponsoring institution Charles Drew Sickle Cell Board responsible.

I hereby certify that the Sickle Cell health history and the general health history and medical history as stated above is correct and I freely sign the above consent to treatment. This authorization shall remain effective until revoked.

Date: _____ Signature: _____

Indicate Relationship: Mother Father Legal Guardian

It is expected that each family will supply any oral medications needed. Some emergency medications will be available. (NOTE: Medication will be given only by camp physician or nurse.)

Name of medication, directions for administering, & child's name must be on the label.

MEDICATIONS TO BE GIVEN DURING CAMP

PLEASE INCLUDE DAILY MEDICATIONS AND ANY AS NEEDED MEDICATIONS YOU ARE SENDING AND ANTICIPATE YOUR CHILD MAY NEED

(ie: Ibuprofen, 200 mg, by mouth, headaches)

TO BE FILLED OUT BY CAMPER'S PARENT/GUARDIAN

Camper's Name: _____ Age: _____ Wt: _____

Allergies: _____

Please fill in the following chart for medications your child will need during camp, you can place an x in the box that fits your child's typical medication timing.

(B=Breakfast 8:30 am, L=Lunch 12:30, D = Dinner 5:30, HS = Bedtime 8:30 for 8-10 years, 9:30 for 12-15 years).

Medications to be given at Northwest Sickle Cell Camp 8/11 - 8/14														
Medication	Dose	Directions	Friday		Saturday				Sunday				Monday	
			D	HS	B	L	D	HS	B	L	D	HS	B	L
ie: Hydroxyurea	500 mg cap	2 cap once daily by mouth		X					X				X	

SICKLE CELL CAMP PHYSICAL FORM

TO BE FILLED OUT BY CAMPER'S PHYSICIAN

Camper's Name: _____

Please list all medications:

Drug Name: _____ Dose: _____ Frequency: _____

Drug Name: _____ Dose: _____ Frequency: _____

Drug Name: _____ Dose: _____ Frequency: _____

Drug Name: _____ Dose: _____ Frequency: _____

Drug Name: _____ Dose: _____ Frequency: _____

Past medical history, operations admissions:

Wt: _____ Ht: _____ T: _____ P: _____ R: _____ BP: _____

GENERAL EXAM:

HEENT: _____ CHEST: _____

ABDOMEN: _____ SPLEEN: _____ LIVER: _____

MSK: _____ NEURO: _____

SKIN: _____ OTHER: _____

Lab Results: Date: _____ WBC: _____ AST/ALT: _____ Bilirubin: _____ HGB: _____ HCT: _____

If antibiotics are necessary at camp, what MED DOSE is recommended for the patient?

PO Antibiotics: _____ Dose: _____

Allergies: _____

Date of most recent tetanus immunization: _____ Last MMR: _____

PRINT Physician's Name: _____ Phone: _____

Physician's Address: _____

Physician's Signature: _____ Date: _____

Some campers come from a distance, in these instances we can try to coordinate with Angel Flight for transportation (requires one month notice)

This camper may or may not fly with Angel Flight West *May* *May not* *(check one)*

This camper is medically stable and can fly in a small non pressurized airplane *Yes* *No* *(check one)*

LIT APPLICATION

TO BE FILLED OUT BY CAMPER

1) Why are you interested in being part of the leader in training (LIT) program?

2) What previous camp experience have you had?

3) What is your experience with Sickle Cell Disease?

VOLUNTEER EXPERIENCE:

(Please list recent volunteer experience, especially experience working with children and youth.)

Organization:

Contact Name:

Phone:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**SICKLE CELL CAMP
DROP OFF OF CAMPERS**

1. I will bring my child to the drop off point for transportation to camp _____.
 2. My child will need a ride to reach the drop off point for camp _____.
Ride help is available from OBCC for Seattle families and on an individual basis for Tacoma and South Sound Families
 3. My child lives > 2 hours away from camp and requires an angel flight arranged _____.
(Angel flight transportation needs to be arranged at least one month in advance of camp)
-

**SICKLE CELL CAMP
CAMPER PICK-UP AUTHORIZATION**

1. I will pick up my child from the camp pick up point _____.
 2. I hereby authorize _____, _____,
(Name) (Phone)
to pick up my child, _____, at the conclusion of Sickle Cell Camp, in my absence.
-

**SICKLE CELL CAMP
CAMPER BEHAVIOR AGREEMENT**

I understand that my child will be required to follow camp rules for safety purposes.

1. No cursing, foul language, disrespectful comments or bullying to campers or staff.
2. Campers must stay with their counselors and follow safety and behavior rules.
3. No hitting, fighting, or inappropriate physical contact
4. I understand that the use or possession of alcohol, illegal drugs, tobacco products, or weapons is prohibited on the property of Camp Burton. No smoking is allowed.

Violation of rules 1 or 2 will have progressive discipline; 1) warning, 2) separation from camp activity, 3) calling of parent. Violation of rules 3 or 4 requires immediate removal from camp. Violators of rule 4 will not be allowed to return to camp.

By signing below you state: I understand that campers may be sent home if they do not follow the behavior and safety guidelines for the camp. I understand that violation of any camp rules can result in parents being contacted and the camper sent home. If a child has to be sent home parents will be expected to pick them up from the ferry.

I understand and agree to abide by the behavior and safety guidelines of Sickle Cell Camp.

Parent/Guardian's signature

Camper's signature

CAMP BURTON SICKLE CELL CAMP PACKING LIST

The following list has been prepared for your convenience in planning for camp. Remember that "old" clothes are good camping clothes. It is not necessary to buy a lot of new items for camp. **PLEASE WRITE YOUR CHILD'S NAME ON EVERYTHING (CLOTHES, CAMERA, TOOTHPASTE, ETC.)**

Call Trinna at (253) 403-1169 or Alix (206) 987-7232, if you need assistance getting sleeping bags or rain gear.

Check off items as you get ready to load them into the car:

- Warm sleeping bag or sheet and heavy blanket suitable for an overnight.
(We recommend putting the sleeping page into a duffel bag or stuff bag for easier transportation.)
- Heavy sweater or warm jacket, especially necessary for mornings and evenings.
- Two pairs of shoes (NO toeless shoes). Sturdy, hiking/running shoes for wet grass.
- Warm pajamas/ or night shirt (flannel if you have it).
- T-shirts, sweatshirts including 2 long sleeve shirts
- Shorts and long pants
- Six (6) pairs of underwear and socks
- One (1) towel, one (1) washcloth, soap, toothbrush, toothpaste, comb, brush, shampoo for each child.
(Please let Barbara or Beth know if your child needs a towel or wash cloth.)
- Sunscreen

BRING SEPARATELY:

- MEDICATIONS!!!!!!!**

OPTIONAL:

- | | | |
|--|--|--|
| <input type="checkbox"/> Pillow & case | <input type="checkbox"/> Laundry bag | <input type="checkbox"/> Book (for rest times) |
| <input type="checkbox"/> Sunglasses | <input type="checkbox"/> Camera & film | <input type="checkbox"/> Chapstick |

**PLEASE PUT YOUR NAME ON ALL PERSONAL CLOTHING ITEMS!!
DO NOT BRING VALUABLES OF ANY KIND TO CAMP.**

**LIT participants may bring a cell phone, they can use their phone to communicate with their leaders.
Personal phone use will be allowed only during breaks.**

**ABSOLUTELY NO FIRE WORKS, KNIVES, OR WEAPONS!
This is grounds for dismissal from camp**

LIT APPLICATION

TO BE FILLED OUT BY CAMPER

Write a short essay:

How will you move your focus from being a camper to serving at Sickle Cell Camp?