HFMD TEEN RETREAT APPLICATION February 18-19, 2023

Application Deadline: February 1st, 2023

Name _____ **Birth date** _____ **Sex** _____ **Age** _____**Weight** _____
Last First Initial

Parent or Guardian _____
**please indicate preferred number below
Home Phone _____**Cell Phone** _____**Work Phone** _____ **E-mail** _____

Address _____
Street and Number City State Zip

Emergency Name _____ **Phone** _____
(If you cannot be reached)

Physician's Name _____ **Phone** _____

NAME AND SEVERITY OF BLEEDING DISORDER: _____

Inhibitor: ☐Yes (Bethesda Units) _____ ☐No

Bleed Prevention Plan (Product used and schedule)_____

Does your child do self-infusion or injection? ☐Yes ☐No

Bleed Treatment Plan (Product that would be used and dose):_____

Hospitalizations in the past year ☐Yes ☐No If yes, describe_____
_____

Major sites of hemorrhage during the past year (target joints) _____
_____

List surgical procedures, dates and/or major complications in the past year _____
_____

Does your child have any drug allergies? ☐Yes ☐No → If yes, specify drug and reaction_____
_____

Bee sting, food or other allergies ☐Yes ☐No → If yes, please explain food or other and reaction_____
_____

Does your child have any physical restrictions that would prevent him/her from participating in any camp activities?
☐Yes ☐No If yes, please explain:_____
_____

Does your child use splints, braces, crutches or wheelchair occasionally during a bleed? ☐Yes ☐No → If yes, please list
_____

Does your child have other medical problems such as heart disease, kidney disease, seizures, diabetes, history of tuberculosis, etc? Please be specific:_____
_____

Please list all medications that the individual is now taking and which are necessary while at the retreat (include PRN pain medications and non-prescription meds)

Medication	Dosage	Frequency

MEDICAL INSURANCE INFORMATION:

Name of Insurance:_____ Commercial Insurance☐ State Insurance☐

Policy Holder Name:_____

ID Number:_____Group Number:_____

IMPORTANT – This CONSENT FORM section must be signed by custodial parent/guardian

I will supply all needed factor concentrate and DDAVP for use at camp. If my child is on prophylaxis, **I will supply those scheduled doses, plus one extra.** If my child treats only when bleeding occurs, I will send at least one dose with him/her. I understand that my child will not be accepted at camp without the needed medications.

**If your child has an inhibitor please discuss factor and plan for camp with your HTC nurse or provider.

Parent/guardian signature _____

I have read and understand all the above information. I agree not to send my child to camp if he/she has been exposed to a contagious disease within three weeks of the date he/she is to report to camp and to notify my child's hemophilia center and the camp director immediately.

_____ _____

Signature of custodial parent/guardian if applicant is under 18 Date

MEDIA RELEASE: HFMD and HTC Publications

HFMD, and the Hemophilia Treatment Centers use photographs, images and recordings of applicants for publication in brochures, email, website and social media applications to promote services or to recruit volunteers and staff. The applicant named above MAY be included in these promotional materials.

I give consent to use my child's name, photograph, and comments in publicizing the works of HFMD and the regional Hemophilia Centers.

☐Yes ☐No

_____

Signature of parent, legal guardian, or authorized person Date

SEND COMPLETED and SIGNED APPLICATION VIA EMAIL OR MAIL TO:

Becca Shaheen, HTC Program Coordinator
becca.shaheen@childrensmn.org | 612-813-7004
2530 Chicago Ave S Suite 175
Minneapolis, MN 55404