



Dear Parent(s):

Greetings from True Friends and HFMD. We are pleased to announce the 30th year of our summer camp, a partnership between the Hemophilia Foundation of MN/Dakotas (HFMD), True Friends and your regional Hemophilia Treatment Centers (HTCs). **This year camp will again be held at Courage North in Lake George, MN.** Lake George is located approximately 3½ hours NW of the Twin Cities.

We will be offering a camp session for boys and girls ages 8 through 17 years with significant bleeding disorders that will run from **Sunday July 7th – Friday July 12th**. Some 7-year-olds may be eligible based on an assessment by the HTC your child attends.

Enclosed you will find the 2019 Camp Application, Health Form, and Transportation Form. Please complete and return ALL forms to True Friends as soon as possible at:

Zach Orner
6350 Indian Chief Rd
Eden Prairie, MN 55346

Applications are due by June 7, 2019 - this application reserves a place at camp for your child, and placement will be assigned on a first-come, first-served basis. Camp tends to fill up quickly, so please return the forms as possible.

FINANCIAL INFORMATION:

Camp is sponsored by the HFMD and your Regional HTC and is offered at NO CHARGE to your child with a bleeding disorder.

The Hemophilia Foundation of Minnesota/Dakotas, your Regional HTC, and True Friends provide young people with bleeding disorders the opportunity to attend summer camp at Courage North. Any boy or girl in Minnesota, North Dakota and South Dakota with a significant bleeding disorder, who wants to attend camp, is eligible to have their entire camp fee paid for by the HFMD. The packing list will be included in the Camper Handbook that each camper will receive in the mail after registering. Please contact your HTC Social Worker if you need financial assistance with items on the packing list. **No child will be turned away because of a lack of funding.**

Please contact me if you have further questions.

Sincerely,

Zach Orner
Manager of Camping, True Friends

HEMOPHILIA/BLEEDING DISORDERS CAMP

To be completed by parent/guardian

Application Deadline: June 7, 2019



HEMOPHILIA FOUNDATION OF MINNESOTA/DAKOTAS



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

Parent(s) or Guardian(s) _____

**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)

Please explain any special custodial information that may apply: _____

Patient Diagnosis _____ Hemophilia Treatment Center _____

Does your child have allergies (drugs, bees, food ...) Yes No If yes, please explain food or other reaction: _____

Does your child have any diet restrictions Yes No If yes, please describe: _____

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: _____

We ask the following questions not to exclude campers, but to assist us in providing the highest levels of care and support to your child during his/her camp experience:

- 1. Describe any social, emotional, behavioral, or communication challenges he/she faces on a regular basis: _____
2. Describe any significant changes or events in his/her life over the last year or so: _____
3. Describe any diagnosed mental health conditions that he/she faces: _____
4. Has your child ever been separated from parents and siblings in the past? Yes No.
5. Do you anticipate a have a problem with separation? Yes No

CABIN ROOMMATE REQUEST:

No roommate preference: _____ Applicant would like to room with: _____
While we will do our best to accommodate all requests, final cabin placement may be limited due to age-ranges and capacity.

How did you hear about Hemophilia/Bleeding Disorder Camp?

- Web site _____
 Friend _____
 Brochure _____
 Doctor/Nurse _____
 Other _____

Camper's Name: _____

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

<u>Medication(s) Coming To Camp</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE NOTE: When camper arrives at camp, the nurse will collect all medications. Be sure medications are labeled with **camper's name, name of drug, dosage, medication time, doctor, prescription number and pharmacy**. Unused medicine will be returned to camper the last day of camp.

IMMUNIZATION RECORD REQUIRED BY MINNESOTA STATE LAW. PARTICIPANTS CANNOT BE ACCEPTED IF THIS IS INCOMPLETE

- | | | | |
|--|------------|--|------------|
| <input type="checkbox"/> Polio Vaccine | Date _____ | <input type="checkbox"/> Tdap booster | Date _____ |
| <input type="checkbox"/> MMR Vaccine | Date _____ | <input type="checkbox"/> Hepatitis A Vaccine | Date _____ |
| <input type="checkbox"/> PCV | Date _____ | <input type="checkbox"/> Hepatitis B Vaccine | Date _____ |
| <input type="checkbox"/> MCV Vaccine** | Date _____ | ** (MCV (Meningococcal) for ages 12 and above only) | |

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 two extra.** If my child treats only when bleeding occurs, I will send at least two doses with him/her. I understand that my child will not be accepted at camp or on the bus 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 hereby authorize the use of donated factor product (recombinant factor VIII, recombinant factor IX, or vW containing factor as appropriate) as needed for emergencies if there is no product from home remaining.

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 _____

MEDICAL INSURANCE INFORMATION:

Name of Insurance: _____
Commercial Insurance State Insurance

Card Holder Name: _____

Group Number: _____

ID Number: _____

Camper's Name: _____

ATTENDANCE AND EMERGENCY RELEASE

Attendance Release: I hereby give my permission for the applicant named above, to participate in True Friends (TF) sponsored and supervised programs. **I certify that the information on the application is true, accurate and complete.** TF emphasizes safety first; however participation in TF programs has inherent risks that may result in injury. I acknowledge and accept this fact and agree to hold harmless True Friends, HFMD, and the associated HTC's, its employees, and agents.

Emergency Release: I hereby give permission to the medical staff selected by True Friends to provide routine health care, administer prescribed and comfort/first aid medications, and if needed, seek emergency medical treatment including x-rays, routine tests and treatment for applicant named above. **In the event that I cannot be reached in an emergency,** I hereby give permission to the physician selected by True Friends to secure and administer treatment including hospitalization, injections, anesthesia or surgery, for the applicant named above. I give permission to obtain copies of treatment and health records from any provider and I agree to release information and records necessary for treatment. True Friends cannot assume responsibility for any medical expenses that may occur if medical care must be sought.

(REQUIRED) Signature of parent, legal guardian, applicant if own guardian, or authorized person

Date

MEDIA RELEASE

True Friends, HFMD, and HTC Publications

True Friends and its partners, 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.

Media Release

I give consent to use my child's name, photograph, and comments in publicizing the works of True Friends, HFMD, and the regional Hemophilia Centers. Unless "No" is marked, consent is assumed.

_____ Yes _____ No

Signature of parent, legal guardian, or authorized person

Date

APPLICATION FEE

(Please check a box below)

- My check for \$45 is enclosed
- Charge the application fee on my VISA or MasterCard (provide card info below)
- Please waive the \$45 fee (fee will be covered by the Hemophilia Foundation of Minnesota & the Dakotas)

Name on card

Card #

Expiration date

SEND COMPLETED APPLICATION TO:

Zach Orner
6350 Indian Chief Rd
Eden Prairie, MN 55346

HEMOPHILIA/BLEEDING DISORDERS CAMP HEALTH FORM



To be completed by Hemophilia Treatment Center

Child's Name _____ Date of examination _____

DOB: _____ Height: _____ cm Weight: _____ kg Allergies: _____

Bleeding Disorder: type & severity _____ Factor level(s): _____

Hospitalizations or major sites of hemorrhage during the past year: _____

Inhibitor status and date drawn: _____ Half-life of factor product if known: _____

Hemophilia product(s) patient uses: _____

Prophylaxis DOSE & SCHEDULE FOR CAMP: _____

Bleed treatment plan - include frequency for re-dosing after initial bleed dose: _____

Hemophilia products and amount that are recommended to bring to camp: _____

Does the individual use Amicar or Lysteda as needed? Yes No If yes, please describe use _____

Port? No Yes If yes, any special instructions? Any reaction to Choraprep in the past? _____

Additional health issues: _____

Current non-bleeding disorder related medications (Name)	Dose	Route	Frequency

I understand that while attending Minnesota Hemophilia Camp, my patient will receive needed medical services as determined, authorized and prescribed by medical personnel staffing the camp.

Return this form to:
Zach Orner
6350 Indian Chief Rd
Eden Prairie, MN 55346

Provider's Name/Address/Phone (Please Print)

Provider's Signature

Date

2019 Camp Transportation Form



Camper's Name

True Friends and the Hemophilia Foundation of Minnesota/Dakotas will provide bus transportation to and from Hemophilia Camp. Please indicate whether you will be riding the bus or providing your own transportation to camp by checking the appropriate option below. Staff will be riding on the bus to assist campers as needed.

Transportation TO Camp Courage North

_____ My child will be **taking the bus provided.**

Check-In: Sunday, July 7th, 8:45 a.m.

- Children's Specialty Center: 2530 Chicago Ave. S. (1st floor) Minneapolis, MN 55404.
- Families can park in the GREEN ramp.
- Arrive by 8:45 a.m. to allow sufficient time to check in camper and his/her medications.
- Bus departs at 10:00 a.m. sharp for Courage North

--OR--

_____ I will **provide my child's transportation** to Hemophilia Camp at Courage North

Check-In @: Sunday July 7th, 1:30 p.m.

- Camp Courage North, 37569 N Courage Dr, Lake George, MN 56458

Please provide the name of the person bringing your child to camp: _____

Transportation FROM Camp Courage North

_____ My child will be **taking the bus provided.**

Check-Out: Friday, July 12th

- Bus arrives at Children's Specialty Center at approximately 3:00 p.m.

--OR--

_____ I will **provide my child's transportation** from Courage North

Check-Out: Friday July 12th, 11 a.m. sharp.

- Pick your child up at Camp Courage North, 37569 N Courage Dr, Lake George, MN 56458

Please provide the name of the person picking your child up from camp and provide their phone and email:

Name

Phone

Email:

Parent/Guardian Signature

Date