HEMOPHILIA/BLEEDING DISORDERS CAMP APPLICATION

To be completed by parent/guardian

Application Deadline: June 7, 2019

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 ROOMATE 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)

Medication(s) Coming To Camp	Dosage	Frequency

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

☐ **Polio Vaccine**	**Date ________**	☐ **Tdap booster**	**Date ________**
☐ **MMR Vaccine**	**Date ________**	☐ **Hepatitis A Vaccine**	**Date ________**
☐ **PCV**	**Date ________**	☐ **Hepatitis B Vaccine**	**Date ________**
☐ **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 HTCs, 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