April 7, 2021

Hello Camp Friends!

We are excited to announce that summer camp is back for 2021! This year marks the 31st anniversary of our summer camp partnership between the Hemophilia Foundation of Minnesota/Dakotas (HFMD), True Friends and your regional Hemophilia Treatment Centers (HTCs).

Please note that the timing and location of this years' camp has changed from previous years. 2021 camp will be held **Sunday, June 27th – Friday, July 2nd** at **True Friends Camp Courage South, 8046 83rd St NW, Maple Lake, MN 55358.**

We are taking all precautions to make sure that campers and staff remain healthy and safe. We ask that all guardians and campers read and sign the "COVID-19 Safety Pledge" included in the application packet. These safety measures include campers doing the following:

- I will wash my hands frequently and when asked to do so
- I will maintain a physical distance of 6 feet from others when able
- I will wear a mask unless I am swimming, sleeping, or eating
- I will tell a counselor or healthcare staff if I am feeling sick

Due to the COVID-19 safety measures in place, we are limited to a maximum of 64 campers for the entire campus of Camp Courage South. We ask that you please fill out all the forms completely and return them by June 1st, 2021.

Please send your completed forms by email (preferred) or postal mail to Allison Albright, HTC Program Coordinator at Children's Hospitals and Clinics of Minnesota. Please also contact Allison if you have any questions.

Email: allison.albright@childrensmn.org *This is the preferred and quickest method to ensure your spot*

Mail: Children's Hospital of Minnesota
Attn: Allison Albright
2530 Chicago Avenue South
CSC 175
Minneapolis, MN 55404

Phone: (612) 813-7064

Thank you for your continued support of camp and our community.

We hope to see you all soon!

Melissa Andrisani
Event Coordinator
Hemophilia Foundation of Minnesota/Dakotas
612-242-9664
melissaa@hfmd.org

Bleeding Disorders Camp

**To be completed by parent/guardian

Application Deadline: June 1st, 2021

Name: _____

Birthdate: _____ Sex: _____ Age: _____

Parent(s) or Guardian(s): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

* Please indicate preferred phone number above

Email: _____

Address: _____

Street and Number City State Zip Code

Emergency Name: _____ Phone: _____

(If you cannot be reached)

Please explain any special custodial information that may apply: _____

Bleeding Disorder Diagnosis: _____ Hemophilia Treatment Center: _____

Treatment: _____

Does this camper have any allergies (drugs, bees, food, etc.)? ☐ Yes ☐ No

If yes, please explain food or other reaction: _____

Does this camper have any dietary restrictions?

If yes, please explain: _____

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 their camp experience:

1. Describe any social, emotional, behavioral, or communication challenges they face on a regular basis:

   _____

2. Describe any significant changes or events in their life over the last year or so:

   _____

3. Describe any diagnosed mental health conditions that they face:

   _____

4. Has your child ever been separated from parents and siblings in the past?:

   _____

5. Do you anticipate having a problem with separation?:

   _____

Cabin Roommate Request:

Applicant would like to be in a cabin with: _____

- While we will do our best to accommodate all requests, final cabin placement may be limited due to age-ranges and capacity

Camper's Name: _____

Please list any other medical issues you want staff to be made aware of:

_____

_____

PLEASE NOTE: When campers arrive at camp, health staff will collect all medications. Be sure medications are in prescription bottles with **camper's name, name of drug, medication time, prescription number, and pharmacy.** Unused medicine will be returned to camper on the last day of camp.

**The dispensing of medications at camp is complicated and we are asking for assistance. Specifically, we request that campers and their families provide only medications that were prescribed by their health care providers during the week of camp. Medications such as vitamins and health supplements can be safely held during the week of camp and resumed when the child returns home without negative consequences. If you have questions or concerns about holding a supplement or OTC medication the week of camp, please contact your HTC team in advance. In addition, camp has a supply of OTC medications for pain, allergies, mosquito bites, upset tummies and more that will be provided if needed.

Immunization record required by Minnesota State Law. Participants cannot be accepted if this is not complete:

- ☐ Polio Vaccine Date: _____
- ☐ MMR Vaccine Date: _____
- ☐ PCV Date: _____
- ☐ MCV Vaccine* Date: _____
- ☐ Tdap Booster Date: _____
- ☐ Hepatitis A Vaccine Date: _____
- ☐ Hepatitis B 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 the bleeding disorder treatment medications for use at camp. **If my child is on prophylaxis, I will supply those scheduled doses, plus an emergency dose**. If my child treats only when bleeding occurs, I will send an emergency treatment along with them. 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 our 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 they have been exposed to a contagious disease within three weeks of the date they are to report to camp and to notify my child's hemophilia center and the camp director immediately.

Parent/guardian signature: _____ 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, 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, guardian, or authorized person Date

APPLICATION FEE
(Please check a box below)

☐ My check for $45 made payable to "HFMD" 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/Dakotas

_____

Name on card Card # Expiration Date

Complete and return with Camp Application

COVID-19 Safety Pledge

We want to ensure a safe experience for all of our campers and staff. **This means if a camper shows signs of illness (fever, nausea, vomiting, cough) they will be isolated from other campers and families will be contacted to pick up their camper as soon as possible.**

Please sign below to demonstrate that you agree to follow Camp Courage's COVID protocols during the duration of camp.

I pledge to do my part to keep myself, other campers, and camp staff healthy and safe by doing the following:

- I will wash my hands frequently and when asked to do so
- I will maintain a physical distance of 6 feet from others when able
- I will wear a mask unless I am swimming, sleeping, or eating
- I will tell a counselor or healthcare staff if I am feeling sick

_____

Camper Signature Date

_____

Parent Signature Date

Complete and return with Camp Application

2021 Camp Courage Transportation Form

Due to COVID-19 protocols, we will **not** be providing bus transportation to/from camp. We will assign a staggered check-in time for you to drop your camper off at Camp Courage. Details on your designated check-in time will be sent to you after we have received your application.

Transportation TO Camp Courage

Check In: Sunday, June 27th between 2:00 and 5:00 PM

* We will assign a specific check-in time somewhere in this range for you. This will be communicated to you after we have received your application

Where: True Friends Camp Courage South
8046 83rd St NW
Maple Lake, MN
55358

Please provide the name and phone number of the person bringing your child to camp:

_____ _____
Name Phone #

Transportation FROM Camp Courage

Check Out: Friday, July 2nd between 10:00 AM – 12:00 PM

Where: True Friends Camp Courage South
8046 83rd St NW
Maple Lake, MN
55358

Please provide the name and phone number of the person bringing your child to camp:

_____ _____
Name Phone #

Complete and return with Camp Application

Bleeding Disorders Camp Health Form

**To be completed by Hemophilia Treatment Center

Child's Name: _____ Date of Examination: _____

DOB: _____ Weight: ____kg Allergies: _____

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

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

Hemophilia product(s) camper uses: _____

Prophylaxis dose and 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 camper use Amicar or Lysteda as needed? __ YES __ NO. If yes, please describe use:

_____

Port? __ YES __ NO. If yes, any special instructions? Needle size? Any reaction to Choraprep in the past?

_____

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

_____

Additional health issues (please include *any* issues that camp health staff should be aware of):

_____

_____

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

_____

Provider's Name/ HTC Name/Phone Number

_____ _____

Provider's Signature Date

FOR HTC STAFF: Please send/scan completed health form to Allison Albright at allison.albright@childrensmn.org