THE HOLE IN THE WALL GANG CAMP

2016 Family Camp Application

Who can come?

- Families with a child(ren) between the ages of 5 and 15 who have the condition we are serving that weekend.
- Immediate family members only.
- Siblings can be any age.

What happens during Family Camp?

- Fun, fun, fun for the whole family!
- Camp activities (fishing, arts & crafts, woodworking, climbing tower, and more)
- Evening activities (campfire, games, stage night)
- Parent Chat

What is the cost?

- Free of charge, thanks to the generosity of our sponsors and donors.

Where do we stay?

- Families are housed together as a family unit.
- Each family has private sleeping quarters and bathroom.
- The Hole In The Wall Gang Camp is a non-smoking and alcohol-free facility.

Medical coverage:

- Parents and Guardians are responsible for the medical care of their child(ren).
- Medical staff will be available on site for support as needed 24/7 during the weekend.

Transportation:

- Transportation assistance may be provided depending on the region. Any questions, please contact us.

2016 Family Camp Weekend

Family Camp: June 2 – June 5, 2016

THE HOLE IN THE WALL GANG CAMP

Family Camp Application Checklist

a seriousfun camp

The application must be complete before it can be reviewed. A complete application contains three (3) parts. Please note that incomplete information will delay your application. We appreciate your timely response in obtaining missing information.

Part I - General Information: To be completed by Parent or Guardian.

Part II - Family Medical and Consent Form: To be completed by Parent or Guardian.

- A form **MUST** be completed for **EACH** family member who will be attending (this does not need to be signed by a healthcare provider).
- It is important that each family medical form is completed thoroughly as our medical team considers the information provided to determine participation of certain activities.
- With the recent outbreaks of Measles and Mumps around the US it is important that everyone who comes to THITWGC be fully immunized against these diseases. You are immune if you received 2 vaccinations against each of these diseases or if you have had the disease and it was diagnosed by a health care provider. Please complete the immunization portion of the medical form for each family member attending (including adults) and/or send a copy of each person's immunization record.

PART III – Medical Information: to be completed by diagnosed child's Health Care Provider (Primary Care or Sub-Specialty Physician or Nurse Practitioner)

a. Medical Form: General medical information, physical exam and medications
b. Immunization Form
c. Diagnosis Specific Form
d. Catheter or Infusion Pump Form: if applicable

PLEASE NOTE

- You will be notified when the application is received.
- Due to the number of applications, not every family that applies can be accepted.
- If your family is not accepted, you will be placed on a waitlist.
- Acceptances will be mailed 2-4 weeks prior to the Family Weekend.
- If your family is accepted, we kindly ask that all family members stay at camp for the entire weekend.
- Family weekends are for immediate family members only.

Applications may be mailed or faxed*:
The Hole in the Wall Gang Camp
Camper Admissions
565 Ashford Center Road
Ashford, CT 06278
Fax to: (860) 429-7295

Questions? Please call us at:
860-429-3444
or visit our website at
www.holeinthewallgang.org

***Please call Camp office to confirm fax has been received.**

THE HOLE IN THE WALL GANG CAMP

Family Camp

GENERAL INFORMATION

(to be completed by Parent or Guardian)

1. Which program are you applying for?

□ Family Camp: June 2 – June 5, 2016

2. Has your child or family previously attended Camp? □ No □ Yes, When? _____

3. Do you need assistance with transportation for the weekend? ☐ Yes ☐ No

4. Camper(s) (Child with the condition we are serving):

Camper(s) Name: _____Birth Date: _____

Gender: _____Diagnosis: _____

5. Parent or Guardian Information (names of those who are attending):

Parent/Guardian Name: _____Birth Date: _____ Gender _____

Relationship to Camper: _____ Cell Phone: _____

Home Phone: _____Email Address: _____

Primary Language: _____ Do you speak English? ☐ Yes ☐ No

Parent/Guardian Name: _____Birth Date: _____ Gender _____

Relationship to Camper: _____ Cell Phone: _____

Home Phone: _____Email Address: _____

Primary Language: _____ Do you speak English? ☐ Yes ☐ No

Primary Mailing Address: Street: _____

City: _____ State: _____ Zip: _____

6. Who has legal custody for all the children under 18? _____

7. Additional Family Members attending (immediate family only):

Name: _____ Birth Date: _____ Gender _____

Name: _____ Birth Date: _____ Gender _____

Name: _____ Birth Date: _____ Gender _____

8. Emergency Contact: (other than family member attending the weekend)

Name: _____ Relationship to child: _____

Phone: _____ Alt. Phone: _____

9. Clinic Information:

Name of clinic or hospital: _____

Who are your child's health care providers?

Specialist: _____ Phone: _____

Primary Care: _____ Phone: _____

10. Please check any special needs your family may have:

☐ Refrigerator for medications

☐ Mobility Issues _____

☐ First Floor Housing

☐ Dietary Needs _____

☐ Other _____

11. Please share any additional information about your family: (fun facts, birthdays, anniversaries, big news, etc.)

_____

_____

Media Release & Special Permissions

I do_____ or I do not_____ **(select one)** give my permission and approve the use of my family's image, name, biographical information and/or audio recording (and/or my child's image, name, biographical information or audio recording if subject is a minor) to be used by The Hole In The Wall Gang Camp as part of its fundraising efforts, advertising, publicity, promotion or any other use. I understand and agree that my image, information and/or audio recording may appear in any media now known or hereafter invented including but not limited to print materials, video, online presentations or other media. I hereby waive any right to inspect and approve the uses to which it may be applied. Nothing herein will constitute any obligation on The Hole In The Wall Gang Camp to use any of the above rights.

I do _____ or I do not _____ **(select one)** give my family and/or my child permission to participate in confidential and voluntary program evaluation at The Hole in the Wall Gang Camp.

I do_____ or I do not_____ **(select one)** wish to receive informational materials from Camp such as newsletters and other publications.
This permission/authorization, including all of its subparts, is effective until revoked in writing.

Consent for Disclosure of Information

I am aware that the Camp has outreach programming including, but not limited to Hospital Outreach Program and CampOut. I understand that should my child ever participate in these Programs, the Outreach Staff may have access to information about my child which may be relevant to his/her participation in Camp programs. I understand that only the minimum necessary information will be disclosed and that all reasonable steps are taken to protect the privacy and confidentiality of my child's information.

I do _____ or do not _____ (select one) give my permission to the sharing of any relevant information between Outreach Staff and Camp staff. *For more information about Outreach Programs please visit our website: www.holeinthewallgang.org*

Parent/Guardian Signature_____Date_____

THE HOLE IN THE WALL GANG CAMP

Family Medical Form – ADULT (18 and over)

This form must be completed for EACH ADULT (18 and over) coming to camp.
Please make copies as necessary.

It is important that both forms are completed thoroughly as the medical team considers the information provided to determine participation for certain activities.

1. Name: _____ Birth Date: ____/____/_____ Age _____

2. Your relationship to camper: _____

3. Drug allergies: _____

4. Food allergies: _____

5. Special Diet Needs: _____

6. Medications: _____

_____

7. Please list any past or ongoing medical conditions and/or considerations:_____

_____

8. Please list any past or on-going behavioral and/or mental health concerns:_____

_____

9. Activity limitations or restrictions:_____

_____

10. Does participant use any mobility devices (wheelchair, walker, crutches, etc)? ☐ NO ☐ YES

If yes, please explain_____

11. IMMUNIZATIONS: please attach a copy of your immunization records

	YES	NO	Dates of vaccine, titers, or illness
Are you immune to Measles?*			
Are you immune to Mumps?*			
Are you immune to Rubella?*			
Are you immune to Varicella?**			
Have you had the Tdap vaccine?			

*2 doses of vaccine are required. If you were born before 1957 you are considered immune

**2 doses of vaccine are required

FAX COMPLETED FORM TO (860) 429-7295

THE HOLE IN THE WALL GANG CAMP

Consent Form – ADULT (18 and over)

This form MUST be completed for EACH ADULT (18 and over) coming to camp.
Please make copies as necessary.

Name: _____ Birth Date: ____/____/_____ Age _____

Mailing Address: (if different from address listed under contact information)

Street: _____

City: _____ State: _____ Zip: _____

CONSENT FOR MEDICAL TREATMENT

I hereby grant, in the event it is necessary, permission to the health care staff at The Hole in the Wall Gang Camp or consulting physicians; to obtain laboratory tests, x-rays, administer routine and other medication, and to provide any emergency or routine care required for _____
(Adult's Name)

CONSENT FOR ACTIVITIES

I do _____ or I do not _____ **(select one)** agree that I and/or my child is authorized to participate in any and all officially administered, sponsored or sanctioned activities at The Hole In The Wall Gang Camp, including, but not limited to: (1) Supervised boating and fishing, (2) Supervised wall climbing, (3) archery. Certain medical conditions may limit participation in specific programs and may require additional medical authorization from your medical provider.

For more program details, including a full list of activities offered on family weekends please visit our website: www.holeinthewallgang.org

I/We would like to discuss the following program areas further: _____

This form may be photocopied for use outside of camp.

Signature: _____ Date: _____

Relationship: _____ Date:_____

FAX COMPLETED FORM TO (860) 429-7295

THE HOLE IN THE WALL GANG CAMP

Family Medical Form – ADULT (18 and over)

This form must be completed for EACH ADULT (18 and over) coming to camp.
Please make copies as necessary.

It is important that both forms are completed thoroughly as the medical team considers the information provided to determine participation for certain activities.

1. Name: _____ Birth Date: ____/____/_____ Age _____

2. Your relationship to camper: _____

3. Drug allergies: _____

4. Food allergies: _____

5. Special Diet Needs: _____

6. Medications: _____

_____

7. Please list any past or ongoing medical conditions and/or considerations:_____

_____

8. Please list any past or on-going behavioral and/or mental health concerns:_____

_____

9. Activity limitations or restrictions:_____

_____

10. Does participant use any mobility devices (wheelchair, walker, crutches, etc)? ☐ NO ☐ YES

If yes, please explain_____

11. IMMUNIZATIONS: please attach a copy of your immunization records

	YES	NO	Dates of vaccine, titers, or illness
Are you immune to Measles?*			
Are you immune to Mumps?*			
Are you immune to Rubella?*			
Are you immune to Varicella?**			
Have you had the Tdap vaccine?			

*2 doses of vaccine are required. If you were born before 1957 you are considered immune

**2 doses of vaccine are required

FAX COMPLETED FORM TO (860) 429-7295

THE HOLE IN THE WALL GANG CAMP

Consent Form – ADULT (18 and over)

This form MUST be completed for EACH ADULT (18 and over) coming to camp.
Please make copies as necessary.

Name: _____ Birth Date: ____/____/_____ Age _____

Mailing Address: (if different from address listed under contact information)

Street: _____

City: _____ State: _____ Zip: _____

CONSENT FOR MEDICAL TREATMENT

I hereby grant, in the event it is necessary, permission to the health care staff at The Hole in the Wall Gang Camp or consulting physicians; to obtain laboratory tests, x-rays, administer routine and other medication, and to provide any emergency or routine care required for _____
(Adult's Name)

CONSENT FOR ACTIVITIES

I do _____ or I do not _____ **(select one)** agree that I and/or my child is authorized to participate in any and all officially administered, sponsored or sanctioned activities at The Hole In The Wall Gang Camp, including, but not limited to: (1) Supervised boating and fishing, (2) Supervised wall climbing, (3) archery. Certain medical conditions may limit participation in specific programs and may require additional medical authorization from your medical provider.

For more program details, including a full list of activities offered on family weekends please visit our website: www.holeinthewallgang.org

I/We would like to discuss the following program areas further: _____

This form may be photocopied for use outside of camp.

Signature: _____ Date: _____

Relationship: _____ Date:_____

FAX COMPLETED FORM TO (860) 429-7295

THE HOLE IN THE WALL GANG CAMP

Family Medical Form – CHILD (17 and under)

This form must be completed for EACH CHILD, including camper (17 and under) coming to camp. Please make copies as necessary.

It is important that both forms are completed thoroughly as the medical team considers the information provided to determine participation for certain activities.

1. Name: _____ Birth Date: ____/____/_____ Age _____

2. Child's relationship to camper: _____

3. Drug allergies: _____

4. Food allergies: _____

5. Special Diet Needs: _____

6. Medications: _____

_____

7. Please list any past or ongoing medical conditions and/or considerations:_____

_____

8. Please list any past or on-going behavioral and/or mental health concerns:_____

_____

9. Activity limitations or restrictions:_____

_____

10. Does participant use any mobility devices (wheelchair, walker, crutches, etc)? ☐ NO ☐ YES

If yes, please explain_____

11. Is the child's development appropriate for his or her age? ☐ YES ☐ NO

If No, at what age does child function?_____ Please explain:_____

_____

12. IMMUNIZATIONS: please attach a copy of immunization records

	YES	NO	Dates of vaccine, titers, or illness
Are you immune to Measles?*			
Are you immune to Mumps?*			
Are you immune to Rubella?*			
Are you immune to Varicella?*			
Have you had the Tdap vaccine?			

*2 doses of vaccine are required

FAX COMPLETED FORM TO (860) 429-7295

THE HOLE IN THE WALL GANG CAMP

Consent Form – CHILD (17 and under)

This form MUST be completed for EACH CHILD, including camper (17 and under) coming to camp. Please make copies as necessary.

Name: _____ Birth Date: ____/____/_____ Age _____

Mailing Address: (if different from address listed under contact information)

Street: _____

City: _____ State: _____ Zip: _____

CONSENT FOR MEDICAL TREATMENT

I hereby grant, in the event it is necessary, permission to the health care staff at The Hole in the Wall Gang Camp or consulting physicians; to obtain laboratory tests, x-rays, administer routine and other medication, and to provide any emergency or routine care required for _____
(Child's Name)

CONSENT FOR ACTIVITIES

I do _____ or I do not _____ **(select one)** agree that my child is authorized to participate in any and all officially administered, sponsored or sanctioned activities at The Hole In The Wall Gang Camp, including, but not limited to: (1) Supervised boating and fishing, (2) Supervised wall climbing, (3) archery. Certain medical conditions may limit participation in specific programs and may require additional medical authorization from your medical provider. Please see Diagnosis Specific Form for more information.

For more program details, including a full list of activities offered on family weekends please visit our website: www.holeinthewallgang.org

I/We would like to discuss the following areas further: _____

This form may be photocopied for use outside of camp.

Signature: (Parent/ Guardian of child) _____Date: _____

Relationship: (Parent/ Guardian of child) _____

FAX COMPLETED FORM TO (860) 429-7295

THE HOLE IN THE WALL GANG CAMP

Family Medical Form – CAMPER

This form must be completed for EACH CHILD, including camper (17 and under) coming to camp. Please make copies as necessary.

It is important that both forms are completed thoroughly as the medical team considers the information provided to determine participation for certain activities.

Name: _____ Birth Date: ____/____/_____ Age _____

2. Child's relationship to camper: _____

3. Drug allergies: _____

4. Food allergies: _____

5. Special Diet Needs: _____

6. Medications: _____

_____

7. Please list any past or ongoing medical conditions and/or considerations:_____

_____

8. Please list any past or on-going behavioral and/or mental health concerns:_____

_____

9. Activity limitations or restrictions:_____

_____

10. Does participant use any mobility devices (wheelchair, walker, crutches, etc)? ☐ NO ☐ YES

If yes, please explain_____

11. Is the child's development appropriate for his or her age? ☐ YES ☐ NO

If No, at what age does child function?_____ Please explain:_____

_____

12. IMMUNIZATIONS: please attach a copy of immunization records

	YES	NO	Dates of vaccine, titers, or illness
Are you immune to Measles?*			
Are you immune to Mumps?*			
Are you immune to Rubella?*			
Are you immune to Varicella?*			
Have you had the Tdap vaccine?			

*2 doses of vaccine are required

THE HOLE IN THE WALL GANG CAMP

Consent Form – CAMPER

This form MUST be completed for EACH CHILD, including camper (17 and under) coming to camp. Please make copies as necessary.

Camper's Name: _____ Birth Date: ____/____/_____ Age _____

Mailing Address: (if different from address listed under contact information)

Street: _____

City: _____ State: _____ Zip: _____

CONSENT FOR MEDICAL TREATMENT

I hereby grant, in the event it is necessary, permission to the health care staff at The Hole in the Wall Gang Camp or consulting physicians; to obtain laboratory tests, x-rays, administer routine and other medication, and to provide any emergency or routine care required for _____
(Camper's Name)

CONSENT FOR ACTIVITIES

I do _____ or I do not _____ **(select one)** agree that my child is authorized to participate in any and all officially administered, sponsored or sanctioned activities at The Hole In The Wall Gang Camp, including, but not limited to: (1) Supervised boating and fishing, (2) Supervised wall climbing, (3) archery. Certain medical conditions may limit participation in specific programs and may require additional medical authorization from your medical provider. Please see Diagnosis Specific Form for more information.

For more program details, including a full list of activities offered on family weekends please visit our website: www.holeinthewallgang.org

I/We would like to discuss the following areas further: _____

This form may be photocopied for use outside of camp.

Signature: (Parent/ Guardian of camper) _____Date: _____

Relationship: (Parent/ Guardian of camper) _____

FAX COMPLETED FORM TO (860) 429-7295

THE HOLE IN THE WALL GANG CAMP – **FAMILY CAMP**

PART III- MEDICAL EXAM FORM - Page 1 of 2

MUST BE COMPLETED BY HEALTH CARE PROVIDER

REQUIRED: PHYSICIAN(S) CONTACT AND INFORMATION	
Specialty Dr:	Pediatrician/Other Dr:
Hospital:	Hospital:
Address:	Address:
Phone:	Phone:
Emergency Phone:	Emergency Phone:
E-Mail:	E-Mail:

GENERAL INFORMATION:

Camper Name: _____ Birthdate: _____

Primary Diagnosis: _____ Date of Diagnosis: _____

Please List Current Problem(s) or Secondary Diagnoses: Comments:

_____ _____

_____ _____

_____ _____

Drug Allergies: _____

Food Allergies:_____

Environmental Allergies: (bees, latex etc.)_____

Does this child have:

Central Venous Catheter	□ Yes	□ No	If Yes, please complete CV Catheter Form
G-tube/J-tube	□ Yes	□ No	If Yes, please complete Infusion Pump Form
TPN	□ Yes	□ No	If Yes, please complete Infusion Pump Form
IV or subcutaneous medications	□ Yes	□ No	If Yes, please include in medication list

Please list all surgeries and dates: _____

_____

_____

FAX COMPLETED FORM TO (860) 429-7295

THE HOLE IN THE WALL GANG CAMP – **FAMILY CAMP**

PART III- MEDICAL EXAM FORM - Page 2 of 2

Camper Name: _____ Birthdate: _____Date of Exam: _____

PHYSICAL EXAM: Please list any pertinent physical findings or attach a recent history & physical.

Height: ft _____ cm _____ Weight: lbs _____ kg _____ BP _____

Pertinent Findings: _____

_____

_____

MEDICATIONS:
Complete Physician's order is required for all medications including OTC and PRN medications that will be administered at camp. Please attach list if more space is needed.

Name of Medicine	Dose	Route	Frequency

Pertinent Psychosocial Information: _____

_____

Essential laboratory studies to be done while child is at camp _____

_____

Are there any special suggestions or restrictions for this camper?_____

_____

PHYSICIAN'S STATEMENT:
I have examined _____and find him/her physically able to attend Camp. I understand the
(***Child's Name Mandatory)***
above medical regimen will be followed while the camper is at camp.

_____ _____ _____
SIGNATURE OF PROVIDER MANDATORY *PRINT NAME* *DATE MANDATORY*

_____ _____
Clinic / Day Phone Emergency / On Call Phone

THE HOLE IN THE WALL GANG CAMP- **FAMILY CAMP**

PART III- IMMUNIZATION FORM

MUST BE COMPLETED BY HEALTH CARE PROVIDER

Please complete the chart below with dates or attach a copy of the immunization history.

Camper Name:_____Birthdate_____

Chicken Pox

*Immunity is **REQUIRED** unless contraindicated*

Camper is immune by one of the following:

- ○ Clinical Disease Date _____
- ○ Varivax Vaccine #1 Date _____
  Varivax Vaccine #2 Date _____
- ○ Positive Titer Date _____
- ○ Camper is not immune and the vaccine is contraindicated. *Reason contraindicated:* _____

MMR

*Immunity if **REQUIRED** unless contraindicated*

Camper is immune by one of the following:

- ○ MMR #1 Date _____
  MMR #2 Date _____
- ○ Positive Titer Date _____
- ○ Camper is not immune and the vaccine is contraindicated. *Reason contraindicated:* _____

Hepatitis B

*3 shot series **REQUIRED** unless contraindicated*

Hep B #1 Date _____
Hep B #2 Date _____
Hep B #3 Date _____

- ○ Camper is not immune and the vaccine is contraindicated. *Reason contraindicated*: _____

Polio

*3-4 doses **REQUIRED** unless contraindicated*

Polio #1 Date _____
Polio #2 Date _____
Polio #3 Date _____
Polio #4 Date _____

- ○ Camper is not immune and the vaccine is contraindicated. *Reason contraindicated:* _____

DPT, DT, Tdap (Tetanus & Pertussis)

*4 shot series **REQUIRED** unless contraindicated*
*If ≥ 11 years old Tdap is **REQUIRED***

DPT/DT Date _____
DPT/DT Date _____
DPT/DT Date _____
DPT/DT Date _____
Tdap Date _____

- ○ Camper is not immune and the vaccine is contraindicated. *Reason contraindicated:* _____

Recommended Vaccines

We strongly recommend the following vaccines. They are not required for Camp attendance

Hepatitis A

Dose #1 Date _____
Dose #2 Date _____

Pneumococcal Vaccine

○ Pneumovax Date _____ Date _____
○ Prevnar Date _____ Date _____

HIB

Date _____ Date _____
Date _____ Date _____

Menactra

Date _____

Immunization Exemption

If the child is exempt from immunizations please explain. _____

_____

_____

_____

I certify that this immunization information was transferred from the above-named individual's medical records.

_____ _____ _____

SIGNATURE OF PROVIDER *PRINT NAME* *DATE*

THE HOLE IN THE WALL GANG CAMP- **FAMILY CAMP**

PART III – CANCER FORM

MUST BE COMPLETED BY HEALTH CARE PROVIDER

_____ _____ _____

Signature of Provider **Print Name** **Date**

Camper's Name _____ **DOB** _____

Diagnosis: _____ Date of Diagnosis: _____

Date of relapse (if applicable) _____

Treatment:

Is the child on therapy? □ Yes □ No If yes, please give details of most recent chemo (date, meds):

_____

If not, when was chemotherapy completed? _____

Has the child had a stem cell transplant? □ Yes □ No Date _____

Does this child have long term side effects from his/her treatment or disease? □ Yes □ No

If yes, please explain: _____

_____

If the child has a central venous catheter please complete CVC Form.

Labs:

Most recent or typical blood counts: Date _____

Hb _____ Hct _____ WBC _____ ANC _____ Plt _____ Other _____

Laboratory studies to be done while camper is at camp: (Please limit to labs that are essential!)

Date _____ Labs _____

Results to be sent to: Name _____ Fax or Phone _____

Additional Comments:

_____

_____

_____

PLEASE SEND UPDATED INFORMATION REGARDING TREATMENT AND/OR CARE IF THERE ARE SIGNIFICANT CHANGES PRIOR TO CAMP

(Including relapse, recent chemo, recent labs, etc.)

FAX COMPLETED FORM TO (860) 429-7295

THE HOLE IN THE WALL GANG CAMP - **FAMILY CAMP**

PART III – SICKLE CELL ANEMIA

MUST BE COMPLETED BY HEALTH CARE PROVIDER

_____ _____ _____

Signature of Provider **Print Name** **Date**

Camper's Name _____ **DOB** _____

What hemoglobinopathy does the child have? (SS, SC, etc.) _____

What is the child's baseline room air oximetry? _____

What complications has the child had?

	Yes	No	Comments/Date
Frequent VOC			
Acute Chest Syndrome			
Stroke			
AVN			
Priapism			
Splenic Sequestration			
Bacteremia/Infection			
Gallstones			
Sleep Apnea			

Does the child have splenomegaly? □ Yes □ No If Yes, spleen size _____

Is this child on a chronic transfusion protocol? □ Yes □ No

History of allo/auto antibodies? □ Yes □ No Details _____

History of transfusion reaction? □ Yes □ No Details _____

Please provide most recent or baseline labs: Date _____

Hb _____ Hct _____ Retic _____ WBC _____

CXR _____ Date _____

Pain Protocol:

Mild Pain _____

Moderate (increasing) Pain _____

Severe Pain _____

Additional Information: _____

FAX COMPLETED FORM TO (860) 429-7295

THE HOLE IN THE WALL GANG CAMP - **FAMILY CAMP**

PART III – BLEEDING DISORDERS FORM

MUST BE COMPLETED BY HEALTH CARE PROVIDER

_____ _____ _____

Signature of Provider **Print Name** **Date**

Camper's Name _____D.O.B._____

Type of bleeding disorder: _____ Hemophilia _____ von Willebrand Disease _____ Other

HEMOPHILIA:

(If the child has von Willebrand disease please complete the other side of this form)

What type? □ A / factor VIII □ B / Factor IX □ Other _____

What is the severity? □ Mild □ Moderate □ Severe Factor level _____

History of inhibitors? □ Yes □ No Details: _____

Target or restricted joints: _____

Treatment:

What brand of factor is used?_____

Can any other brand be used? □ Yes □ No If yes please specify_____

Is the child on prophylactic factor replacement? □ Yes □ No

FACTOR THERAPY - Required	Dose	Frequency
Prophylactic Therapy		
Minor bleeds		
Joint bleeds		
Major bleeds		
Trauma or Head Injury		

Does the child self-infuse? □ Yes □ Yes, with assistance □ No □ No, but would like to learn

Does the child receive any other treatment such as Stimate of Amicar? □ Yes □ No

Please provide dose and instructions:

MEDICATIONS	Dose	Frequency
Amicar		
Stimate		
Other:		

Activity Permission:

Can the child participate in horseback riding? □ Yes, without pretreatment □ Yes, with pretreatment □ No

Can the child participate in a low ropes adventure course? □ Yes, without pretreatment □ Yes, with pretreatment □ No

Can the child participate in a high ropes adventure program (climbing wall and zip line with harness safety system)? □ Yes, without pretreatment □ Yes, with pretreatment □ No

FAX COMPLETED FORM TO (860) 429-7295

THE HOLE IN THE WALL GANG CAMP - **FAMILY CAMP**

PART III – BLEEDING DISORDERS FORM

VON WILLEBRAND DISEASE

Camper's Name _____D.O.B._____

What type of vWD does the child have? □ Type 1 □ Type 2 □ Type 2B □ Type 2N □ Type 3

How often does the child have problems with bleeding?

□ Rarely (< once a month) □ Often (once a week)

□ Occasionally (> once a month, < once a week) □ Frequently (> once a week)

Please describe the type and severity of the child's bleeding episodes: _____

_____

_____

Treatment:

What treatment does the child require? □ DDAVP / Stimate □ Amicar □ Factor Infusion □ Other

How often does the child require treatment?

□ Rarely (< once a month) □ Often (once a week)

□ Occasionally (> once a month, < once a week) □ Frequently (> once a week)

Please provide medications, doses, and frequency

MEDICATIONS	Dose	Frequency

Has the child had Emergency Room visits and/or hospitalizations due to bleeding? □ Yes □ No
If yes, please describe _____

_____

Activity Permission:

Can the child participate in horseback riding? □ Yes, without pretreatment □ Yes, with pretreatment □ No

Can the child participate in a low ropes adventure course? □ Yes, without pretreatment
□ Yes, with pretreatment □ No

Can the child participate in a high ropes adventure program (climbing wall and zip line with harness safety system)?
□ Yes, without pretreatment □ Yes, with pretreatment □ No

Additional Information:

_____

_____

FAX COMPLETED FORM TO (860) 429-7295

THE HOLE IN THE WALL GANG CAMP - **FAMILY CAMP**

PART III – METABOLIC/MITOCHONDRIAL FORM

MUST BE COMPLETED BY HEALTH CARE PROVIDER

_____ _____ _____

Signature of Provider **Print Name** **Date**

Camper's Name _____D.O.B._____

Diagnosis: _____ Date of Diagnosis: _____

ACTIVITY LEVEL

What is the child's typical activity level? _____

How much time does he/she spend outside? _____

DIET/FLUIDS

How much fluid does the child need in a day?_____

Does the child need their blood sugar checked? □ Yes □ No If yes, how often and at what times of the day?

_____

What dietary restrictions/requirements does the child have? _____

_____

MEDICAL EMERGENCIES - please attach a copy of the child's emergency protocol

What are the early signs that the child is decompensating?_____

_____

What should treatment be provided? _____

_____

_____

What are the signs that their illness is progressing and that more aggressive treatment is needed?_____

_____

What should treatment be provided? _____

_____

_____

When does the child need to go to the hospital? _____

FAX COMPLETED FORM TO (860) 429-7295

THE HOLE IN THE WALL GANG CAMP - **FAMILY CAMP**

PART III – IMMUNOLOGY FORM

MUST BE COMPLETED BY HEALTH CARE PROVIDER

_____ _____ _____

Signature of Provider **Print Name** **Date**

Camper's Name _____D.O.B._____

Diagnosis: _____ Date of Diagnosis: _____

ACQUIRED IMMUNODEFICIENCY:

Is child aware of his or her diagnosis? □ Yes □ No Details: _____

Is child compliant with medications? □ Yes □ No Details: _____

Most recent or typical blood counts: Date _____

Hb _____ Hct _____ WBC _____ ANC _____ Plt _____

CD4+ Cell Count/% _____ Viral Load Copy _____

Other _____

Additional Comments:_____

_____

CONGENITAL IMMUNODEFICIENCY:

Please describe any infectious issues the child has: _____

_____

_____

Does this child receive immunoglobulin replacement? □ Yes □ No If yes, what product _____

Schedule:_____

Has the child ever had a reaction to immunoglobulin? □ Yes □ No If yes, please explain _____

_____

Does the child have a scheduled protocol or work up in the event of fever? □ Yes □ No If yes, please explain, or attach a copy of the protocol _____

_____

Additional Comments:

_____

_____

_____

FAX COMPLETED FORM TO (860) 429-7295

THE HOLE IN THE WALL GANG CAMP - **FAMILY CAMP**

PART III – OTHER DIAGNOSIS FORM

MUST BE COMPLETED BY HEALTH CARE PROVIDER

_____ _____ _____

Signature of Provider **Print Name** **Date**

Camper's Name _____D.O.B._____

Diagnosis: _____ Date of Diagnosis: _____

Is this child currently receiving treatment? □ Yes □ No If yes, please explain _____

_____

_____

How is the child affected by the diagnosis?_____

_____

_____

Does the child have any other medical problems? □ Yes □ No If yes, please explain _____

_____

_____

Does the child have dietary restrictions or allergies? □ Yes □ No If yes, please explain _____

_____

_____

Most recent or typical blood counts: Date _____

Hb _____ Hct _____ WBC _____ ANC _____ Plt _____

Other _____

Additional Comments: _____

_____

_____

_____

FAX COMPLETED FORM TO (860) 429-7295

THE HOLE IN THE WALL GANG CAMP - **FAMILY CAMP**

CV CATHETER FORM

Complete this form only if the child has a central line (Broviac, Hickman, Portacath, etc.)

TO BE COMPLETED BY HEALTH CARE PROVIDER

All necessary supplies (dressing kits, heparin, syringes, access needles, numbing spray or cream, etc.) must be sent to Camp with child. Children will need 7 dressing kits (or equivalent supplies for the week) if they plan on swimming every day.

Camper Name: _____ Birthdate: _____ Date: _____

Type of catheter: (External) Broviac/Hickman _____
Single lumen _____ Double lumen _____

(Internal) Portacath/ Infusaport _____

Other _____

Specific Instructions for catheter care:

How often is it flushed with heparin? _____

What amount & strength of heparin is used? _____

What size needle is used for access? _____ gauge _____ length

What kind of numbing cream or spray is used?_____

How often is the dressing changed? _____

When is the cap changed? (day of the week) _____

Does this child do any or all of their own catheter care? □ Yes □ No

If Yes, please explain _____

_____

May this line be used to draw blood? □ Yes □ No

What, if any, medications are to be infused into this line during the Camp period?

_____

_____

Special instructions: _____

_____

CENTRAL LINE CONSENT - Unless otherwise specified, all children will be permitted to swim.

This child: ☐ DOES ☐ DOES NOT have permission to go swimming in a chlorine-treated swimming pool. (Dressings will be changed immediately following swimming)

_____ _____

Physician's Signature **Date**

FAX COMPLETED FORM TO (860) 429-7295

THE HOLE IN THE WALL GANG CAMP - **FAMILY CAMP**

INFUSION PUMP FORM

Complete this form only if the child uses a desferal infusion pump, TPN pump, gastrostomy feeding pump, etc

TO BE COMPLETED BY HEALTH CARE PROVIDER

You must send all supplies including medication, sterile water, needles, syringes, batteries to camp.

Camper Name: _____ Birthdate: _____ Date: _____

Manufacturer and model of pump _____

Contact number for service or replacement_____

Instructions for medication infusion pumps

Medication:_____

Dose:_____

Mixing Instructions (Diluent Amount):_____

Length and rate of infusion:_____

Frequency of infusion while at Camp. Days of week?_____

Instructions for g-tube feeds or TPN

Continuous feeds/TPN:

Product and Quantity:_____

Infusion rate:_____

Infusion times:_____

Bolus Feeds:

Product and Quantity:_____

When is it given?_____

How is it given? (pump, gravity, push):_____

Additional Information:_____

_____

_____

_____

FAX COMPLETED FORM TO (860) 429-7295