



Kay's Kamp Kamper Application

Thank you so much for your interest in Kay's Kamp. Kamp will run from Sunday, August 8, 2010 through Saturday, August 14, 2010. All campers can attend free of charge. Attached you will find an application that needs to be completed for your child. Please make sure that you sign all appropriate areas.

The last two pages are a required authorization that is needed from your child's physician or nurse practitioner. **We do not need these forms to process your application, but we do need these forms in order for your child to attend Kamp.** Please do not let this form hold up sending in your application, you can always send or fax it to us later. Once you have all required information and signatures, please forward the application to the following address:

Kaylyn Elaine Warren Foundation
560 Peoples Plaza #111
Newark, DE 19702
Attn: Camper Application
Or fax it to:
(302)-836-8534

Please be sure to include the following with your application:

- Recent picture of your camper**
- Copy of Medical Insurance Card, front & back**
- Copy of most recent blood work if your camper is currently on therapy**

Once we have received your child's completed application, it will be reviewed by our Medical Director to ensure that our staff can provide the services your child may need while at Kay's Kamp. Once the application has been reviewed, you will receive an acceptance letter in the mail with all of the important information you will need to know, including camper drop-off and pick-up times. Please make sure to regularly check the Kamp website at www.kayskamp.org for updates on information.

We realize the decision to send your child to camp for a week can be a difficult and emotional one, but camp can be a wonderful opportunity for your child to experience lots of fun and confidence building experiences. My experienced staff and I are ready to answer any questions or address and concerns you or your child may have about Kay's Kamp or the application process. To reassure parents even more, we send daily newsletters during Kamp so you can follow along with the activities and maybe even catch a glimpse of your camper in action!

Please do not hesitate to contact me at lisa@kayskamp.org. My staff and I look forward to meeting you and your future camper! Go Kamp!!

Lisa Schmalbach
Executive Director
Kamp Director

****FOR USE BY KAMP STAFF ONLY****
Enter the date for the following information

Application received: _____ Complete Original application given to Volunteer Coordinator _____
Complete copy given to Kamp Director _____ Medical Director _____



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** Please include a recent photograph of your child with this application. **

General Information			
Camper's Name		Preferred name for nametag	
Street Address			
City	State	Zip	Home Phone
D.O.B.	Current grade in school		Age at camp
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Camper's email address	
Does Camper have a Caring Bridge, Care Page or other Web Page that may become accessible to Kamp staff?			
Camper's T-Shirt size YS <input type="checkbox"/> YM <input type="checkbox"/> YL <input type="checkbox"/> AS <input type="checkbox"/> AM <input type="checkbox"/> AL <input type="checkbox"/> AXL <input type="checkbox"/> AXXL <input type="checkbox"/>			
Do you have siblings? yes <input type="checkbox"/> no <input type="checkbox"/> Name/age of sibling(s)			
Diagnosis			Date of Diagnosis
Currently: on therapy <input type="checkbox"/> off therapy <input type="checkbox"/>			
Name of Parents/Guardian with whom child lives			
Relationship to child		Parent/guardian email	
Name of Individual(s) with Legal Custody of Child:		Any specific legal arrangements or restrictions regarding custody which Kamp should be made aware of:	
Home Phone	Work Phone	Cell Phone	
May Kay's Kamp contact you and send correspondence through email? Yes <input type="checkbox"/> No <input type="checkbox"/>			
May we publish you child's address, phone number and email in the <u>Counselor</u> directory? yes <input type="checkbox"/> no <input type="checkbox"/>			
May we publish you child's address, phone number and email in the <u>Camper</u> directory? yes <input type="checkbox"/> no <input type="checkbox"/>			
Emergency Contact – <i>Please list two alternative adults to contact in case of an emergency if parent/guardian cannot be reached. Must be someone OTHER than parent/Guardian.</i>			
1. Name		Relationship	
Home Phone	Work Phone	Cell Phone	
2. Name		Relationship	
Home Phone	Work Phone	Cell Phone	
Is either of the above Emergency Contacts authorized to pick your child up from Kamp if needed?	If so, which one(s)?	Please have a handwritten note that is signed, dated and available to be given to camp staff if the Emergency contact is to be used to pick up your child.	

Has your child ever been convicted of a crime? No Yes

If yes, explain the number of conviction(s), nature of offense(s) leading to conviction(s), how recently such offense(s) was/were committed, sentence(s) imposed, and type(s) of rehabilitation completed."



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Does your child use any special equipment such as a walker, crutches, wheel chair or prosthesis?

Please list any physical restrictions or activity limitations (i.e. no water sports, no prolonged sun exposure, no competitive sports, sight or hearing impairment or loss, limb amputation, difficulty walking distances, requires assistance to dress or eat, etc.).

Is there anything we should know about your child's behavior that will make their adjustment to camp smoother or easier for them to be successful?

Is your child able to function at his or her age level? Please describe.

Describe any bedtime/sleep habits (i.e. talks/walks in sleep, toys, sleeps with parent, etc.).

Please indicate any further information about your child's medical and/or emotional needs that you feel we should know about.

If possible, what other camper(s) would your child like to be in a cabin with?



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Kay's Kamp Consent Form

The following consent agreement must be signed by a parent or legal guardian of the minor child in order for the child to attend Kay's Kamp.

Your signature below indicates approval of the following:

1. In the event that my child, _____, participates at Kays Kamp during the 2010 session, I hereby waive, release and discharge any and all claims for damages, death, personal injury or property damage which I may have, or which may hereafter accrue to me as a result of my child's participation in the Kamp's activities. This release is intended to discharge in advance Kay's Kamp and all of it's agents, representatives, volunteers and employees from any and all liability, claims, costs, expenses and/or damages (collectively referred to as "liability") arising out of or connected in any way with my child's participation in the activities of the Kamp, even though that liability may arise out of negligence or carelessness on the part of the person or entities mentioned above.

I further understand that serious accidents occasionally occur during Kamp activities, and that participation in Kamp activities occasionally sustain mortal or serious personal injuries and/or property damage as a consequence thereof. Knowing the risks of Kamp activities, nevertheless, I hereby agree to assume those risks and to release and hold harmless all of the persons or entities mentioned above who (through negligence or carelessness) might otherwise be liable to my child or to me (or to my heirs or assigns) for damages.

I further agree to indemnify and hold harmless Kay's Kamp in the event or for any other damages any other person, property damages or entity, other than the undersigned, brings an action for the death or personal injuries of my child, as a result of my child's participation in the Kamp's activities.

2. Kay's Kamp accepts no responsibility for the loss, damage or theft of your child's property.
3. Should you as a parent or guardian, during the Kamp session, leave your place of residence; you will advise the Kamp administration where you can be contacted in the event of an emergency.
4. Kay's Kamp maintains an accident insurance policy on campers attending the 2009 summer session. All claims under this policy must be submitted within 30 days of the occurrence of the accident. This policy is in addition to and not in place of health or accident insurance maintained by you.
5. I recognize and understand that Kay's Kamp is operated as a charitable organization. My child and I are receiving all of the benefits of Kay's Kamp with minimal or no costs to us.
6. In case of medical and/or surgical emergency, you authorize Kay's Kamp medical staff to render to your child or to arrange for your child to receive any x-rays, anesthetic, medical, dental, surgical diagnosis, treatment, and hospital care which is deemed advisable by and is rendered under, the supervision of any physician, dentist, surgeon or nurse practitioner licensed to practice in the State of Delaware. I agree to be responsible for all medical transportation and related charges incurred on behalf of my child. I further agree that no Kay's Kamp employee, agent or volunteer will be responsible for injuries or damages arising from the provisions of such emergency treatment or transportation.



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7. I acknowledge that reporters, photographers and other members of the media may attend Kay's Kamp in order to increase the awareness about Kay's Kamp and its programs. I grant permission for my child to be interviewed, photographed and filmed by any member of the media at Kay's Kamp. I understand that Kay's Kamp is not responsible for the content of the media coverage and that my child will not be paid for any media work.
8. Kay's Kamp and its representatives have absolute permission to use my child's image in a photograph or video that pertains to the lawful programs and activities of the Kamp.
9. All information is correct so far as I know and the camper named below has permission to engage in all Kamp activities, except as noted in writing by me or by the physician or PNP completing the Physician/PNP Recommendations and Restrictions form for the camper.

Signature: _____ Date: _____

Print Name: _____ Relationship to Camper: _____

Camper's Name: _____



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KAMPER HEALTH HISTORY FORM

This form is required by all campers. Kay's Kamp will not be able to complete this form for you. You must obtain doctor/PNP signature on page 11 and 12. Please complete the following information so that the Kamp can be aware of all of your child's needs.

Last Name		First		M.I.	Today's Date	
Home Address					Apt. #	
City			State		Zip	
SSN		Gender male <input type="checkbox"/> female <input type="checkbox"/>		DOB		
Diagnosis		Date of Diagnosis		<input type="checkbox"/> on <input type="checkbox"/> off therapy		
Legal Guardian				Relationship		
(Legal Guardian is the Individual with the power to make health care decisions for the child and for whom Camp must always be able to contact at least by telephone)						
Work Phone				Cell Phone		
Name of Oncologist Oncologist Hospital Affiliation:				Phone		
Address						
Name of pediatrician/family doctor:				Phone		
Address						
Name of Dentist				Phone		
Address						
#1 Emergency Contact				Relationship		
Phone (H)		Phone (W)		Phone (C)		
If emergency contact is not available, notify #2 Emergency Contact:						
Phone (H)		Phone (W)		Phone (C)		
Insurance Information						
Primary Medical Insurance Information						
Insurance Company Name						
Street Address			City		State	Zip
Policy Holder's Name				Policy or group #		
Phone Number						
Secondary Medical Insurance Information						
Insurance Company Name						
Street Address			City		State	Zip
Policy Holder's Name				Policy or group #		
Phone Number						
<input type="checkbox"/> Please check this box if your child currently DOES NOT have insurance coverage						
** PLEASE PHOTOCOPY FRONT AND BACK OF HEALTH INSURANCE CARD AND ATTACH TO THIS FORM **						



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Allergies

Please list all known medication, food allergies, and environmental allergies.
(Include insect stings, hay fever, asthma, etc.)

Allergy	Describe reaction and management of the reaction

Additional Medical History

Medical Diagnosis	Approximate Date of Diagnosis	Any Recent Complications or Changes

Surgical History

Surgery	Date, most recent first	Any Complications resulting from surgery

Specialists and/or Therapists

Specialist (<i>Neurologist, Cardiologist, etc...</i>) or Therapist (<i>Occupational, Physical, etc...</i>)	Date of last Appointment	Specific Issue(s) for Which Child is Being Seen



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Medications

The medical staff will store and administer any medications needed during the Kamp session. Please send all medications to Kamp with your child in their original container with written instructions. It is expected that each family will supply in advance any routine medications needed.

Please have your doctor write an order describing the dose and method of administration (including chemotherapy, TPN, antibiotics or other infusion). It is necessary for you to arrange the transport of these medications to Kamp with your healthcare team.

If your child is on therapy, please send the most recent blood counts to Kamp with your child for comparison to any counts which may be needed at Kamp.

My child takes no medication on a routine basis

My child has a port. My child has a central line. (Date of Insertion: _____)

* If you child has a central line, please send the necessary supplies for central line care and flushing. Send enough supplies for at least daily changes.

My child takes the following medications on a routine basis:

DRUG	DOSE and ROUTE	TIME	DAYS OF WEEK

Use additional sheets as necessary to describe the care needed for your child.

Please explain any restrictions to activity (ex: what cannot be done, what adaptations or limitations are necessary).

Dietary restrictions (please be specific).



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General Questions (please check yes or no)

Has your child or Does your child:

1. Had any recent injury, illness or infectious disease? Yes No
2. Have a chronic or recurring illness/injury? Yes No
3. Been hospitalized in the past 18 months? Yes No
4. Had surgery in the last 18 months? Yes No
5. Have frequent headaches or migraines? Yes No
6. Had a head injury? Yes No
7. Been knocked unconscious? Yes No
8. Wear glasses, contacts or protective eyewear? Yes No
9. Passed out during or after exercise? Yes No
10. Been dizzy during or after exercise? Yes No
11. Had seizures? Yes No
12. Had chest pain during or after exercise? Yes No
13. Had high blood pressure? Yes No
14. Been diagnosed with a heart murmur? Yes No
15. Had back problems? Yes No
16. Had problems with joints (knees, ankles, etc.)? Yes No
17. Have any skin problems (itching, hives, rash, acne)? Yes No
18. Have diabetes? Yes No
19. Have asthma? Yes No
20. Had mononucleosis in the past 12 months? Yes No
21. Had problems with diarrhea/constipation? Yes No
22. Have problems sleepwalking? Yes No
23. If female, have abnormal menstrual history? Yes No
24. Had an eating disorder? Yes No
25. Have ADD/ADHD? Yes No
26. Have Developmental Delays? Yes No

Please explain any "Yes" answers, noting the number of the question.

Which of the following has your child been diagnosed with in the past?

Please check all that apply and give approximate date of diagnosis.

- | | | |
|----------------------------------|---|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox or Shingles | <input type="checkbox"/> German Measles (Rubella) |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Pertussis (Whooping Cough) | |



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****Please include a complete copy of your child's up-to-date immunizations.**

VACCINE	DATE
Tetanus, most recent (Td, Tdap or DTaP)	
H1N1 vaccine, if eligible	
2009/2010 Influenza vaccine	
Tuberculin Test, most recent	pos <input type="checkbox"/> neg <input type="checkbox"/> if pos, ____ mm

If you have been exposed to any communicable disease, particularly chicken pox (which is especially dangerous to children on chemotherapy), during the month prior to Kamp, please contact us as soon as possible.

By signing below, I acknowledge my consent to the Kay's Kamp Consent form and I certify that the above information on my child's application and the information provided on the attached Kamper Health History Form are true and correct.

Signature: _____ Date: _____

Print Name: _____ Relationship to Camper: _____

Camper's Name: _____



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**THE NEXT TWO PAGES TO BE COMPLETED BY PHYSICIAN OR PNP
Physician/PNP Recommendations and Restrictions at Kamp**

I examined _____ on _____
Camper's full name date of most recent examination

Weight: _____ Height: _____ BMI: _____ BP: _____ HR: _____ RR: _____

Last blood count: Date: _____ Hgb _____ Hct _____ WBC _____
Platelets _____ ANC _____ Varicella Titer _____

Current physical and medical condition: X=within normal limits O=See remarks below

___ scalp, skin ___ heart ___ vision ___ ear, nose ___ lungs
___ hearing ___ throat ___ abdomen ___ neck ___ eyes
___ genitalia ___ teeth ___ extremities ___ lymph nodes ___ nervous system

REMARKS: _____

Current Chemotherapy. Please include a copy of current chemotherapy roadmap or regimen.

Any medically-prescribed meal plan or dietary restrictions: _____

Description of any limitation, concern or restriction on Kamp activities:

I hereby verify that the information on the above form and preceding forms containing health matters and medications are correct. In my opinion, this child is able to participate in Kay's Kamp Summer Kamp.



Signature of Physician/Practitioner _____

Print Name _____ Date _____

Phone _____



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*Dear Physician or PNP,
Kay's Kamp, the First Oncology Camp in Delaware, is requesting a few moments of your time to complete the following data on your patient, _____ (DOB _____). This information is requested on individuals in treatment and on survivors in order to understand their current health status and ongoing health risks so the medical staff can be adequately prepared and provide the best possible care. Thank you in advance for your assistance.*

Amanda Kay, MD
Medical Director, Kay's Kamp

I authorize the release of the requested medical information below of my child, _____ (DOB _____), to the Kay's Kamp Medical Team. I understand this information will be used solely by the Kamp medical staff for the purpose of ensuring the safe care and well being of my child while at Kay's Kamp. Please complete and return by Fax to the Kay's Kamp Medical Team as soon as possible at: **302-836-8534**.

Print Name of Parent/Guardian: _____
Parent/Guardian: _____ Date: _____

Primary Diagnosis: _____ **Date of Diagnosis:** _____
Additional Diagnoses: _____
Date of Initiation of Treatment: _____
Date of Treatment Completion, if applicable: _____
Treatment Protocol followed: _____

Chemotherapy Type(s) Used: _____

Radiation Used: Yes No
If Yes, Site/Field: _____ **Total Dose** _____

Child's Follow-up Imaging and Studies, as applicable to treatment and diagnosis:

Study, most recent	Date	Findings, if any
ECHO		
EKG		
Pulmonary Function Test		
Chest X-ray		
CT/MRI		
Thyroid function studies		
Renal function studies		
Urinalysis		
Liver function studies		
DEXA or bone density study		
Hearing exam		
Ophthalmology exam		

Additional Information: _____