



A retreat for children with life-threatening illnesses and their families

2012 Family Application for Children with Brain Tumors

Please complete and return this application to the Camp Sunshine office.

Pages 1 - 3 – Parents' forms to be completed Pages 4 - 6 – Physician's forms to be completed

Application Review Policy: Every question must be answered; incomplete applications cannot be reviewed. Please print clearly using black or blue ink.

Patient's last name Patient's first name Name as you would like it to appear on child's nametag Gender Date of Birth Address Apt City State Zip Home telephone E-mail Diagnosis Date of Diagnosis

Treatment Center Address City State Zip Physician (Specialist) Telephone Fax Social Worker Telephone Fax

Health Insurance Company Telephone Policy Holder Policy No. Group No.

Prior Attendance – This is our (please circle one) 1st time 2nd time 3rd time 4th time th time at Camp.

How did you hear about Camp Sunshine?

2012 Brain Tumor Session Dates

Please CIRCLE first choice:

July 15-20 Brain Tumor: Low-Grade Session July 22-27 Brain Tumor

Families of children with brain tumors are also welcome at any of the General Oncology Sessions:

Please CIRCLE first choice:

June 17 - 22 Oncology July 1 - 6 Oncology Aug 3 - 8 Oncology Aug 26 - 30 Oncology\*\* Aug 31- Sept. 4 Oncology Off-Treatment

\*\*Spanish-speaking families are encouraged to apply.

FOR OFFICE USE ONLY

ACA forms sent: Received: Acceptance packet sent: Registration Received: Need for 1:1 Supervision: Yes Wheelchair: Yes Transportation needs: Yes Called Parent/Guardian: Contact Date spoke with Contact Date spoke with

## FAMILY INFORMATION

Name of parent(s) or guardian(s) child lives with: \_\_\_\_\_

Parent/Guardian 1  
Relationship \_\_\_\_\_  
Date of Birth \_\_\_/\_\_\_/\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
E-mail \_\_\_\_\_  
Mobile phone \_\_\_\_\_  
Employer \_\_\_\_\_  
Work Phone \_\_\_\_\_

Parent/Guardian 2:  
Relationship \_\_\_\_\_  
Date of Birth \_\_\_/\_\_\_/\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
E-mail \_\_\_\_\_  
Mobile phone \_\_\_\_\_  
Employer \_\_\_\_\_  
Work Phone \_\_\_\_\_

### Emergency Contact (someone who will not be attending Camp with you)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

**Please list all immediate family members (mother, father, siblings) who will accompany the patient to Camp. (One additional support person may accompany a single parent or a parent whose partner cannot attend.) If any other family member is under the care of a physician or mental health professional, please indicate the nature of the problem.**

Parent's or Legal Guardian's Name*	Relationship & age at the time of Camp	Medical or Emotional problem? If "Yes," please explain
1. _____	( _____ ) _____ yr	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
2. _____	( _____ ) _____ yr	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
<b>Sibling's Name</b>		
1. _____	( _____ ) _____ yr	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
2. _____	( _____ ) _____ yr	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
3. _____	( _____ ) _____ yr	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
4. _____	( _____ ) _____ yr	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
5. _____	( _____ ) _____ yr	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
6. _____	( _____ ) _____ yr	<input type="checkbox"/> No <input type="checkbox"/> Yes _____

**\*IF A LEGAL GUARDIAN WILL BE ACCOMPANYING A CHILD TO CAMP, ORIGINAL NOTARIZED DOCUMENTATION CONFIRMING THE GUARDIANSHIP MUST BE INCLUDED WITH THIS APPLICATION. WE WILL ALSO REQUIRE THIS DOCUMENTATION UPON YOUR ARRIVAL.**

### YOUR CHILD'S GENERAL MEDICAL HISTORY

PLEASE LIST ALL SPECIAL NEEDS SO THAT NECESSARY PREPARATIONS CAN BE MADE.  
THE MORE INFORMATION WE HAVE, THE BETTER WE WILL BE ABLE TO CARE FOR YOUR CHILD.

Primary language: \_\_\_\_\_  
Additional medical problems (such as asthma, diabetes, etc.): \_\_\_\_\_  
Drug allergies: \_\_\_\_\_  
Dietary restrictions or food allergies: \_\_\_\_\_  
Physical limitations: \_\_\_\_\_  
Mobility (e.g., wheelchair, crutches, amputations): \_\_\_\_\_  
Special needs/care requirements (vision/hearing loss): \_\_\_\_\_  
Does your child have seizures?  Yes  No If so, how frequently do they occur? \_\_\_\_\_  
Please describe the type of seizure: \_\_\_\_\_  
What treatment is necessary for the seizures? \_\_\_\_\_ When was the last seizure? \_\_\_\_\_  
Is your child incontinent?  Yes  No If yes:  Bladder  Bowel Is catheterization needed?  Yes  No  
Please provide any additional information to help us care for your child: \_\_\_\_\_  
\_\_\_\_\_

**Permission to use photographs, video tape and/or audio tape of you and/or your family**

On behalf of myself and my family, I do hereby give Camp Sunshine, without consideration or compensation, permission to use photographs, videotape, and/or audiotape that may be taken or recorded while my child and family are attending Camp for promotional, educational, or fundraising activities. It is my understanding that these likenesses may be used to promote public and professional understanding and support of the program. I waive any right that I may have to inspect or approve the finished product or the use to which it may be applied.

Parent/Guardian/Other Adult \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

Parent/Guardian/Other Adult \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

**Permission to use family name in connection with fundraising efforts**

I give my permission for Camp Sunshine to use my/my family's name to help raise funds to support the Camp Sunshine program. I understand that I am to receive no compensation for the use of my/my family's name for these purposes.

Parent/Guardian/Other Adult \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

Parent/Guardian/Other Adult \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

**AUTHORIZATION FOR CAMP SUNSHINE TO PROVIDE MEDICAL TREATMENT**

I hereby give my consent for Camp Sunshine's medical personnel to provide any and all reasonable and necessary medical treatment for my children. I understand and consent that I am responsible for all medical expenses incurred by Camp Sunshine on my behalf or on behalf of any members of my family.

**(Please include all of the children in your family who will be attending Camp Sunshine).**

Children's Names	Date of Birth
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

This authorization shall remain in effect while we are attending Camp Sunshine at Sebago Lake in Casco, Maine.

Parent/Guardian/Other Adult \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

Parent/Guardian/Other Adult \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

I understand and agree that information disclosed regarding any of the individuals named in this application and related documents may be disclosed or otherwise released to appropriate organizations or individuals (including, but not limited to: members of the Camp Sunshine staff, insurance companies, and physicians) in connection with attendance at Camp Sunshine at Sebago Lake, Inc. I hereby confirm that the above information is true and accurate and that once accepted, I agree to update this information as you may request.

Parent/Guardian/Other Adult \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

Parent/Guardian/Other Adult \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

**The patient's portion of the Camp Sunshine application and physical examination form must be sent in together. Updated laboratory studies and status report will be required 1-3 weeks prior to the Camp session.**

## *Physician Guidelines for Camp Sunshine*

**The medical guidelines for patients who wish to attend Camp Sunshine are as follows:**

1. Children are considered medically acceptable to participate in the program if they can be expected to be in good general health at the time of the camp session. We regret that we cannot accommodate patients with renal disease who are on hemodialysis. Children should not attend camp if they are entering into an anticipated period of significant myelosuppression.
2. Children should undergo laboratory testing, when appropriate, prior to attending camp. The "Late Changes" form is to be sent to camp 1-3 weeks in advance of the child's attendance.
3. The Physical Examination form must be completed by the child's subspecialty team and returned along with the child's application.
4. Children should not require any therapy during Camp other than treatment usually administered by parents, with the exception of methotrexate or colony stimulating factors.
5. Children should not require any form of special medical care during the week of Camp, e.g. transfusions.
6. Arrangements for laboratory investigations at Camp should be made in advance by the referring physician, or by the parents with the camp physician upon arrival.
7. **Children or other susceptible family members who have been exposed to varicella (chickenpox) within three weeks of a camp session cannot attend. In the event that a child or family member has been exposed to shingles (herpes zoster), please contact Camp for further guidance.**
8. **Children or family members who have received oral polio vaccine within six weeks of a camp session cannot attend.**
9. Children must be 18 years of age or younger.

**If a child does not meet these guidelines, please contact the Camp Sunshine office directly so the situation can be further assessed.**

It is the intent of Camp Sunshine to provide a respite experience for seriously ill children and their families with as little medical intervention as possible. A physician will be present at Camp to provide evaluation of acute problems. Other than simple first aid and stabilization of acutely ill campers, however, no treatment will be offered at Camp. Transportation will be provided to a nearby medical facility in the event that other treatment is necessary. It is not the intent of Camp Sunshine to provide routine medical care for other family members.

Thank you for helping us to provide a special respite experience for your patients and their families. It is our expectation that children will be qualified as acceptable for referral by their own treating physicians with the above specifications in mind. Children who do not meet the above guidelines will find it inconvenient to receive needed medical care in this setting and should not be encouraged to attend. Please contact the Family Coordinator with any questions regarding the above or any aspect of medical support available for camp participants at 207-655-3800 between 8:30am and 4:30pm Monday through Friday.

Please remit fully completed application to:

Camp Sunshine  
35 Acadia Road  
Casco, ME 04015

Phone: (207) 655-3800 Fax: (207) 655-3825  
<http://www.campsunshine.org>

# CAMP SUNSHINE BRAIN TUMOR PHYSICAL EXAMINATION FORM

The following information should be provided by the pediatric hematology-oncology team treating the child.

Please return to Camp Sunshine, 35 Acadia Road, Casco, Maine 04015

Telephone (207) 655-3800

Fax (207) 655-3825

**THIS APPLICATION CANNOT BE PROCESSED UNTIL ALL THE INFORMATION BELOW IS COMPLETE.**

Child's Name: \_\_\_\_\_

Date of Examination: \_\_\_\_/\_\_\_\_/\_\_\_\_

Diagnosis: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_

Allergies: \_\_\_\_\_

## ❶ Brain Tumor

Is the child on active treatment?

Yes: Date of most recent chemotherapy: \_\_\_\_/\_\_\_\_/\_\_\_\_

No: Date therapy completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

List of surgeries: \_\_\_\_\_

Does the child have a VP shunt?  Yes  No Is it functioning?  Yes  No When was the last revision? \_\_\_\_\_

Describe any recent admissions or serious illnesses: \_\_\_\_\_

Does the child have seizures?  Yes  No What type and frequency? \_\_\_\_\_

Please describe any residual neurologic dysfunction: \_\_\_\_\_

Has the child been under the care of a psychiatrist?  Yes  No Please describe any behavioral, social, emotional, or psychiatric issues that may affect the child: \_\_\_\_\_

## ❷ Central Venous Access

Type of access:  External (Broviac/Hickman)  Internal (Portacath/Infusaport/Mediport)  Not applicable

Special instructions regarding central line/port: \_\_\_\_\_

## ❸ Water Activities/Contact Sports

Can the child swim in a chlorinated indoor pool?  Yes  No

Can the child swim in lake water?  Yes  No

Are there any restrictions or suggestions for this child (contact sports, etc.)? \_\_\_\_\_

Describe any disability or physical limitations affecting other camp activity: \_\_\_\_\_

## ❹ Transfusions

Is the child on a transfusion protocol?  Yes  No Is the child likely to require transfusion during camp?  Yes  No

Has the child ever had a transfusion reaction?  Yes  No Transfusion history of note \_\_\_\_\_

What are guidelines for transfusion? \_\_\_\_\_

What preparation or pre-medication is required? \_\_\_\_\_

## ❺ Bone Marrow/Stem Cell Transplantation

Has the child undergone bone marrow/stem cell transplantation?  Yes  No If yes:  autologous  allogeneic

Date of transplant \_\_\_\_/\_\_\_\_/\_\_\_\_ Have there been any complications related to the transplant? \_\_\_\_\_

## ❻ Varicella (If the following information is not complete, this application cannot be reviewed.)

Please indicate:

\_\_\_\_\_ (1) This child is **IMMUNE** to varicella by reason of (check one or more):

clinical disease (varicella, zoster)  positive titer  Varivax vaccine – **OR** –

\_\_\_\_\_ (2) This child is **NOT IMMUNE** to varicella and the vaccine has not been administered to him/her.

**IN THE EVENT OF A VARICELLA EXPOSURE AT CAMP, WILL THIS CHILD REQUIRE IVIG AND/OR ACYCLOVIR?  YES  NO**

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**7 PHYSICAL EXAMINATION**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respirations: \_\_\_\_\_ BP: \_\_\_\_/\_\_\_\_

Please note all abnormal findings. Check “√” indicates normal.

HEENT \_\_\_\_\_ Musculoskeletal/Back \_\_\_\_\_  
Neck \_\_\_\_\_ Genitalia \_\_\_\_\_  
Lungs \_\_\_\_\_ Neurologic \_\_\_\_\_  
Heart \_\_\_\_\_ Skin \_\_\_\_\_  
Abdomen \_\_\_\_\_ Prostheses? \_\_\_\_\_Comments: \_\_\_\_\_

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**8 LABORATORY INVESTIGATIONS**

Date: \_\_\_\_\_ H/H \_\_\_\_/\_\_\_\_ WBC \_\_\_\_\_ (ANC \_\_\_\_\_) Platelets \_\_\_\_\_

Chemistries: \_\_\_\_\_ Urinalysis: \_\_\_\_\_

Will the child require laboratory tests while at camp? If so, please specify which tests and to whom results should be called/forwarded. (Please limit these to essential studies.) \_\_\_\_\_

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**9 MEDICATIONS\*****WITH THE EXCEPTION OF WEEKLY METHOTREXATE, CHEMOTHERAPY IS NOT ADMINISTERED AT CAMP.**

Please list medications that the child receives routinely (include pain management). Attach additional pages if necessary.

Medication	Dose	Route	Frequency

\*Each family should bring all medications, catheter dressings, and other supplies necessary for their child while at camp.

**10 IS THERE ANYTHING ELSE WE SHOULD KNOW THAT WOULD BETTER ASSIST US IN PREPARING FOR THIS FAMILY TO ATTEND CAMP? IN PARTICULAR, ARE THERE ANY SOCIAL OR EMOTIONAL ISSUES PERTAINING TO ANY FAMILY MEMBER?** \_\_\_\_\_

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***We regret that applications cannot be reviewed unless the signature of the attending hematology-oncology physician or certified oncology nurse practitioner is provided below. Thank you for your cooperation!***

**Attending Physician’s Statement: I have examined \_\_\_\_\_ who is physically able to engage in camp activities except for the limitations and restrictions noted above.****Attending physician’s signature:** \_\_\_\_\_ **Date** \_\_\_\_\_**Type/print name:** \_\_\_\_\_**Address:** \_\_\_\_\_**Telephone:** (\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_) \_\_\_\_\_**Telephone or pager where a physician who is familiar with child can be contacted at night and on weekends:**

(\_\_\_\_) \_\_\_\_\_

**11 PLEASE NOTIFY US OF ANY LAST-MINUTE CHANGES (I.E., MEDICATIONS, LABORATORY RESULTS).**