2017 Dyskeratosis Congenita Camp Information

Thank you for your interest in attending Camp Sunshine. We are pleased to offer Hematology/Oncology, and Mixed Diagnosis sessions for families of children with Dyskeratosis Congenita. Pages 1-3 of the application are for families to complete. Pages 4-6 are for your hematology team to complete.

Eligibility Guidelines

- If both parents are unable to attend, a second adult may attend as a support person and should be included on the application.
- Immunization records are required for everyone under 26 years of age.
- Completed applications will be reviewed on a first-come, first-served basis, and should be received at least one month prior to the session start date. (If seeking to apply within one month of a program, please call Camp Sunshine to inquire about availability.)

Things to Know About Camp

- Meals, lodging, and activities are all provided at no cost to families, thanks to the generosity of our donors.
- A physician is present on-site during all Camp Sunshine sessions.
- Family suites can comfortably sleep 6 and include a private bathroom, heat/AC, a mini-fridge, and microwave oven.
- Transportation assistance may be available for families who would otherwise be unable to attend Camp. Funding is prioritized for families attending for the first time. Please indicate your request for transportation funding on the first page of the application. If requested, you will receive further information at the time of acceptance.
- You will be contacted upon receipt of your application. Acceptances and other updates will be provided as soon as possible.

Applications may be mailed or faxed to:
Camp Sunshine
35 Acadia Road
Casco, ME 04015
Phone: (207) 655-3800
Fax: (207) 655-3825
www.campsunshine.org
2017 Dyskeratosis Congenita Application Checklist

Please use the following checklist to ensure that your family’s application is complete.

- **Family Forms**
  - Pages 1-3 of the application, to be completed by the parent/guardian

- **Physician Forms**
  - Pages 4-6 of the application, to be completed by your child’s specialist

- **Immunization Records**
  - A complete and up-to-date immunization record must be included for each person under 26 years of age who is applying to attend Camp.
  - For the optimal health and safety of all campers, staff, and volunteers, Camp Sunshine requires that all campers who can receive immunizations meet the age-appropriate immunization schedule as set forth by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
  - At a minimum, campers aged 5 years and older should meet the same immunization requirements as those for school-aged children set forth in the State of Maine School Immunization Law (20-A MRSA §§6352-6358):
    - 5 DTap (4 DTap if the 4th is given on or after the 4th birthday)
    - 4 Polio (if the 4th dose is given before the 4th birthday, an additional age-appropriate inactivated polio immunization should be given on or after the 4th birthday)
    - 2 MMR (measles, mumps, rubella)
    - 1 Varicella (chickenpox) or reliable history of disease
  - Camp Sunshine also requires that children aged 11 and older receive meningococcal vaccine and TDBP booster prior to attendance.

- **Health History Forms**
  - A separate Health History form is required for each person (including adults) planning to attend Camp, with the exception of the child with Dyskeratosis Congenita. The Health History forms do not require a physician signature.

- **Session Selection**
  - Please select three session dates, ranked 1-3 in order of preference, on the first page of the application.
  - After your completed application has been reviewed and approved, you will be notified of your assigned session.
  - In placing families, we take into consideration your preferences, timeliness of your application, session capacity, diagnoses, and group composition. We appreciate your understanding and flexibility as we work to meet the needs of the many families who apply.
CAMPER INFORMATION

DC Camper’s last name __________________________ DC Camper’s first name _____________________
Name as you would like it to appear on the DC Camper’s nametag ______________________________
Diagnosis ___________________________________ Date of Diagnosis ___/___/____
Gender  □ Male  □ Female Date of Birth ___/___/____
Address ___________________________________________ Apt _____ City __________ State _____ Zip ______
Home telephone_________________________ E-mail ______________________________

Treatment Center ________________________________
Address ___________________________________________ City __________ State _____ Zip ______
Physician (Specialist) ___________________________________ Telephone ______________________
Social Worker ___________________________________ Telephone ______________________
Child Life Specialist ___________________________________ Telephone ______________________
Health Insurance Company ________________________________ Telephone ______________________
Policy Holder __________________________ Policy No. ___________ Group No. __________

Prior Attendance – This will be our (please circle one) 1st time  2nd time  3rd time  4th time  ____ th time at Camp.
How did you hear about Camp Sunshine? Name ______________________________

2017 Session Dates

Please indicate your preferred session dates (1-3) below. Family applications will be reviewed and accepted for one session per calendar year

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Session Name</th>
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<tbody>
<tr>
<td>Apr 19 – 23</td>
<td>Spring Spirit*</td>
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<tr>
<td>May 25 – 30</td>
<td>Memorial Day Getaway*</td>
</tr>
<tr>
<td>Jul 16 - 21</td>
<td>Hematology/ Oncology</td>
</tr>
<tr>
<td>Aug 31 – Sep 5</td>
<td>Labor Day Getaway*</td>
</tr>
<tr>
<td>Oct 27 – 30</td>
<td>Great Pumpkin Weekend*</td>
</tr>
<tr>
<td>Dec 1 – 3</td>
<td>Holiday Weekend*</td>
</tr>
</tbody>
</table>

* Mixed Diagnosis Sessions: Families of children with any diagnosis served by Camp Sunshine are encouraged to apply
INFORMATION FOR FAMILIES WITH CHILDREN UNDER AGE 18

Name of parent(s) or guardian(s) camper lives with: ____________________________________________

Parent/Guardian 1 ____________________________________________________________

Relationship ________________________________________________________________

Date of Birth __/__/___ ____________________________

Address _________________________________________________________________

City, State, Zip ____________________________

Home Phone ____________________________

Cellular phone ____________________________

E-mail _________________________________________________________________

Employer ________________________________________________________________

Have you been in the Armed Forces? ☐ Yes ☐ No

Have you been in the Reserves? ☐ Yes ☐ No

Are you a member of a Service Organization? ☐ Yes ☐ No

If so, please specify ____________________________________________________________

Parent/Guardian 2: ____________________________________________________________

Relationship ________________________________________________________________

Date of Birth __/__/___ ____________________________

Address _________________________________________________________________

City, State, Zip ____________________________

Home Phone ____________________________

Cellular phone ____________________________

E-mail _________________________________________________________________

Employer ________________________________________________________________

Have you been in the Armed Forces? ☐ Yes ☐ No

Have you been in the Reserves? ☐ Yes ☐ No

Are you a member of a Service Organization? ☐ Yes ☐ No

If so, please specify ____________________________________________________________

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

Name ____________________________ Relationship ____________________________ Telephone ____________________________

**Immediate Family Members Who Will Be Attending Camp**

(One adult support person may accompany a single parent/guardian or a parent/guardian whose partner cannot attend.)

<table>
<thead>
<tr>
<th>Adult Names</th>
<th>Relationship to camper</th>
<th>Medical or Emotional concern? If “Yes,” please explain</th>
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<tbody>
<tr>
<td>1. __________</td>
<td>______________________</td>
<td>☐ Yes ☐ No __________________________________________</td>
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<tr>
<td>2. __________</td>
<td>______________________</td>
<td>☐ Yes ☐ No __________________________________________</td>
</tr>
</tbody>
</table>

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<tr>
<th>Sibling Names</th>
<th>Relationship/age at time of Camp</th>
<th>Medical or Emotional concern? If “Yes,” please explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. __________</td>
<td>____<strong><strong>/</strong></strong> yr</td>
<td>☐ Yes ☐ No __________________________________________</td>
</tr>
<tr>
<td>2. __________</td>
<td>____<strong><strong>/</strong></strong> yr</td>
<td>☐ Yes ☐ No __________________________________________</td>
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<tr>
<td>3. __________</td>
<td>____<strong><strong>/</strong></strong> yr</td>
<td>☐ Yes ☐ No __________________________________________</td>
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<td>4. __________</td>
<td>____<strong><strong>/</strong></strong> yr</td>
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<td>5. __________</td>
<td>____<strong><strong>/</strong></strong> yr</td>
<td>☐ Yes ☐ No __________________________________________</td>
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<tr>
<td>6. __________</td>
<td>____<strong><strong>/</strong></strong> yr</td>
<td>☐ Yes ☐ No __________________________________________</td>
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*PLEASE NOTE: ALL CHILDREN UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY A PARENT AND/OR LEGAL GUARDIAN WHEN ATTENDING CAMP. IF A LEGAL GUARDIAN WILL BE ACCOMPANYING A CHILD TO CAMP, ORIGINAL NOTARIZED DOCUMENTATION CONFIRMING THE GUARDIANSHIP MUST BE INCLUDED WITH THIS APPLICATION.

**DC CAMPER’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: ____________________________

Drug allergies, food allergies, or dietary restrictions: ____________________________________________

Additional medical problems (such as asthma, diabetes, etc.): ______________________________________

Cognitive or gross/fine motor delays: ____________________________________________________________

Does your child have joint pain? ☐ Yes ☐ No  Physical limitations: ____________________________

Mobility (e.g., wheelchair, crutches, amputation): _______________________________________________

Special needs/care requirements (vision/hearing loss): ____________________________________________

Does the DC camper 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 the DC camper incontinent? ☐ Yes ☐ No  If yes: ☐ Bladder ☐ Bowel  Is catheterization needed? ☐ Yes ☐ No

Please provide any additional information to help us care for the DC camper: ____________________________________________

(01/06/2017) 2
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 ____________

Parent/Guardian/Other Adult ____________________________ Signature ____________________________ Date ____________

Permission to use photographs and/or videotape of you and/or your family for postings on Social Media.

On behalf of myself and my family, I do hereby give Camp Sunshine, without consideration or compensation, permission to use photographs and/or videotape that may be taken or recorded while my child and family are attending Camp for postings on social media including but not limited to postings on Camp Sunshine at Sebago Lake’s official facebook page. 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 ____________

Parent/Guardian/Other Adult ____________________________ Signature ____________________________ Date ____________

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 ____________

Parent/Guardian/Other Adult ____________________________ Signature ____________________________ Date ____________

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).

<table>
<thead>
<tr>
<th>Children’s Names</th>
<th>Date of Birth</th>
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This authorization shall remain in effect while we are attending Camp Sunshine at Sebago Lake in Casco, Maine.

Parent/Guardian/Other Adult ____________________________ Signature ____________________________ Date ____________

Parent/Guardian/Other Adult ____________________________ Signature ____________________________ Date ____________

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 ____________

Parent/Guardian/Other Adult ____________________________ Signature ____________________________ Date ____________
Physicians’ Guidelines for Camp Sunshine Applications

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

1. Campers 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.

2. Campers should undergo laboratory testing, when appropriate, prior to attending camp. A “Late Changes” form is to be sent to Camp 1-3 weeks in advance of the patient’s attendance, noting up-to-date laboratory tests and medication changes.

3. The Physical Examination form must be completed by the camper’s subspecialty team and returned along with the camper’s application.

4. Campers should not require any therapy during Camp other than treatment usually administered at home, with the exception of methotrexate or colony stimulating factors.

5. Campers 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 family 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 other family member has been exposed to herpes zoster (shingles), 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.

If a camper 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 respite for your patients and their families with as little medical intervention as possible. A physician will be present at Camp to provide evaluation of acute problems. No treatment will be offered at Camp other than management of routine childhood illnesses and minor injuries. 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 unique 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 submit a 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 PHYSICAL EXAMINATION FORM

The following information must be provided by the pediatric hematologist/oncologist treating the patient.

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.

DC Patient’s Name ________________________________  Date of Examination: ____/____/____

Diagnosis: ________________________________  Date of Diagnosis: ____/____/____

Allergies: __________________________________________

1. Dyskeratosis congenita
   Is the patient on active treatment?  □ Yes □ No
   Dates and nature of most recent therapy: ______________________________
   Date therapy completed: ____/____/____
   Describe any recent admissions or serious illnesses:
   List of surgeries:
   Has the patient been under the care of a psychiatrist? □ Yes □ No
   Please describe any behavioral, social, emotional, or psychiatric issues that may affect the patient:

2. Central venous access
   Type of access: □ External (Broviac/Hickman) □ Internal (Portacath/Infusaport/Mediport) □ Not applicable
   Special instructions regarding central line/port: __________________________________________

3. Water activities/Contact sports
   Can the patient swim in a chlorinated pool? □ Yes □ No
   Can the patient swim in lake water? □ Yes □ No
   Are there any restrictions or suggestions for this patient (contact sports, etc.)?
   Describe any disability or physical limitations affecting other camp activity: ________________________________

4. Transfusions
   Is the patient on a transfusion protocol? □ Yes □ No
   Is the patient likely to require transfusion during camp? □ Yes □ No
   Has the patient ever had a transfusion reaction? □ Yes □ No
   Transfusion history of note ________________________________
   What are guidelines for transfusion? ________________________________
   What preparation or pre-medication is required? ________________________________

5. Hematopoietic stem cell transplantation
   Has the patient undergone stem cell transplantation? □ Not applicable □ Bone marrow □ Peripheral stem cell □ Cord blood
   Donor: □ Related □ Unrelated
   Date of transplant ____/____/____
   Have there been any complications related to the transplant? ________________________________

6. Varicella (If the following information is not complete, this application cannot be reviewed.)
   Please indicate:
   _____ (1) This patient is IMMUNE to varicella by reason of (check one or more):
   □ clinical disease □ positive titer □ Varivax vaccine
   □ OR –
   _____ (2) This patient 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 PATIENT REQUIRE IVIG AND/OR ACYCLOVIR? □ Yes □ No
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:

LABORATORY INVESTIGATIONS

Date: _____ H/H _____/_____ WBC _______ (ANC _______) Platelets _______

Chemistries: ____________________________ Urinalysis:________________________

Will the patient 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.) ____________________________

MEDICATIONS*

WITH THE EXCEPTION OF WEEKLY METHOTREXATE, CHEMOTHERAPY IS NOT ADMINISTERED AT CAMP.

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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
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*Each family should bring all medications, catheter dressings, and other necessary supplies.

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 CONCERNS PERTAINING TO ANY FAMILY MEMBER? ___________

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!

I have examined __________________________ who is physically able to engage in camp activities except for the limitations and restrictions noted above.

Attending physician’s/nurse practitioner’s signature: ________________  Date ________________

Type/print name: ____________________________

Address: ____________________________

Telephone: (____) __________________ Fax: (____) __________________

Telephone or pager where health professional who is familiar with the patient can be contacted at night and on weekends: (____) __________________

PLEASE NOTIFY US OF ANY LAST-MINUTE CHANGES (I.E., MEDICATIONS, LAB RESULTS) ON A LATE CHANGE FORM. ☐
Camper’s Name: ______________________

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

Health History Form

Please complete pages 1 and 2 of this form for each person attending other than the camper. Information must be filled out by a parent/guardian for all minors. Any changes to this form should be provided to Camp Sunshine staff prior to arrival.

Name __________________________     Birth date ___________     Age: _______   Gender: ☐ Male ☐ Female

Relationship to camper _______________________________________________________________________

Address ___________________________     City _______________________     State ________     Zip ________

Parent/guardian __________________________________________     (if applicable)

Insurance Information

Is the participant covered by family medical/hospital insurance? ☐ yes ☐ no

Carrier or plan name _________________________     Policy No. ____________     Group No. ______________

Medications

Please list all medications taken routinely. Bring enough medication to last the entire camp session. Keep all medication in original packaging/bottle that identifies the prescribing drugs.

Med #1_____________________Dosage_____________Specific times taken each day__________________
Reason for taking________________________________________

Med #2_____________________Dosage_____________Specific times taken each day__________________
Reason for taking________________________________________

Med #3_____________________Dosage_____________Specific times taken each day__________________
Reason for taking________________________________________

General Questions (Explain “yes” answers)

1. Have you had any recent injury, illness, or infectious disease? ☐ yes ☐ no
2. Do you have a chronic recurring illness/condition? ☐ yes ☐ no
3. Have you ever been hospitalized? ☐ yes ☐ no
4. Have you ever had surgery? ☐ yes ☐ no
5. Have you ever had a head injury? ☐ yes ☐ no
6. Have you ever been knocked unconscious? ☐ yes ☐ no
7. Have you ever passed out during exercise? ☐ yes ☐ no
8. Have you ever been dizzy during exercise? ☐ yes ☐ no
9. Have you ever had a seizure? ☐ yes ☐ no
10. Have you ever had chest pain during or after exercise? ☐ yes ☐ no
11. Have you ever had high blood pressure? ☐ yes ☐ no
12. Have you ever been diagnosed with a heart murmur? ☐ yes ☐ no
13. Do you have diabetes? ☐ yes ☐ no
14. Do you have asthma? ☐ yes ☐ no
15. Have you ever had an eating disorder? ☐ yes ☐ no
16. Have you ever had emotional difficulties for which professional help was sought? ☐ yes ☐ no

Please explain “Yes” answers, noting the number of the questions:  _______________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Page 1 of 2
Camper’s name __________________________

Name __________________________

Allergies

<table>
<thead>
<tr>
<th>Medication allergies (list)</th>
<th>Describe reaction and management of the reaction</th>
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<tr>
<th>Food allergies (list)</th>
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<th>Other allergies (list)</th>
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Dietary Restrictions

- Does not eat pork
- Does not eat eggs
- Does not eat dairy
- Other (describe) __________________

Explain any restriction to activities (e.g. what cannot be done, what adaptation or limitations are necessary)

____________________________________________________________________________________
____________________________________________________________________________________

Use this space to provide any additional information about participant’s behavior and physical, emotional, or mental health about which camp should be aware: ___________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

To the best of your knowledge, which of the following has the participant had?

- Chickenpox
- Measles
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test Result:
- Positive
- Negative

Name of family physician: _______________________________________ Phone __________________

*(YOU DO NOT NEED A PHYSICIAN’S SIGNATURE)*

**Parent/Guardian/Adult Authorizations:** This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities as noted.

I hereby give permission to Camp Sunshine’s medical personnel to provide any and all reasonable and necessary medical treatment for the person herein described. I further understand and consent that I am responsible for all medical expenses incurred by Camp Sunshine on behalf of the person herein described.

Signature of custodial parent/guardian or adult camper _____________________________ Date ____________

Printed Name ___________________________________________