Thank you for your interest in attending Camp Sunshine. We are pleased to offer Retinoblastoma, Oncology and Mixed Diagnosis sessions for families whose children have been diagnosed with retinoblastoma or another eye cancer. Pages 1–3 of the application are for families to complete. Pages 4–6 are for your oncology or ophthalmology team to complete.

Eligibility Guidelines

- The child with retinoblastoma must be 18 years of age or younger
- If both parents/legal guardians 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.)
- Families may attend once per calendar year

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 funding is 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
2018 Retinoblastoma and Other Eye Cancers 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 TDaP 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 retinoblastoma or another eye cancer. 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.
A retreat for children with life-threatening illnesses and their families

2018 Retinoblastoma and Other Eye Cancers Program
Family Application

Please print clearly using black or blue ink.

CAMPER INFORMATION

Child’s last name _______________________________ Child’s first name _______________________________
Name as you would like it to appear on child’s nametag ________________________________________________
Gender________________________________________ Gender________________________________________
Diagnosis ____________________________ Gender________________________________________
Date of Diagnosis __________/________/__________ Date of Diagnosis __________/________/__________
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 __________________________________________

2018 Session Dates

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

Feb 16 – 20 Oncology
Feb 21 – 25 Oncology
Jun 7 – 12 Oncology
Jun 14 – 19 Retinoblastoma and Other Eye Cancers
Jun 21 – 26 Oncology
Jul 8 – 13 Hematology/ Oncology
Aug 5 - 10 Oncology
Aug 19 – 23 Oncology – Off-Treatment**
Aug 25 – 29 Oncology – Spanish-Speaking
Aug 30 – Sep 4 Labor Day Getaway*
Oct 26 – 29 Great Pumpkin Weekend*
Nov 30 – Dec 2 Holiday Weekend*

* Mixed Diagnosis Sessions: Families of children with any diagnosis served by Camp Sunshine are encouraged to apply
** Families of Children who are 3-5 years post-treatment are encouraged to apply

FOR OFFICE USE ONLY

☐ Family Forms ☐ Immunizations ☐ Physician Forms ☐ Health History Forms

(11/6/2017)
FAMILY INFORMATION

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

Marital status (please indicate marital status of parents and explain any particular familial circumstances and/or custodial arrangements of which we should be aware):

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

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

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

Name: ________________________________
Relationship: ________________________________
Telephone: ________________________________

WHO WILL BE ATTENDING CAMP WITH THE CHILD?

One adult support person may accompany a single parent or a parent whose partner cannot attend.

Parent/ Legal Guardian/ Support Person Names: ________________________________
Relationship to camper: ________________________________
Medical or Emotional diagnosis/ concern?
If “Yes,” please explain and include on Health History Form
☐ No ☐ Yes:

Sibling’s/ Support Person’s Child(ren)’s Names: ________________________________
Relationship/age at time of Camp: ________________________________
Medical or Emotional diagnosis/ concern?
If “Yes,” please explain and include on Health History Form
☐ No ☐ Yes:

1. ________________________________ / yr: ________________________________
☐ No ☐ Yes:
2. ________________________________ / yr: ________________________________
☐ No ☐ Yes:
3. ________________________________ / yr: ________________________________
☐ No ☐ Yes:
4. ________________________________ / yr: ________________________________
☐ No ☐ Yes:
5. ________________________________ / yr: ________________________________
☐ No ☐ Yes:
6. ________________________________ / yr: ________________________________
☐ No ☐ Yes:

*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. IF YOUR MARITAL STATUS IS SEPARATED OR DIVORCED, YOU MAY RECEIVE SUPPLEMENTAL MATERIALS AND PARENTS/ LEGAL GUARDIANS MAY BE REQUIRED TO PROVIDE ADDITIONAL INFORMATION.

YOUR CHILD’S GENERAL MEDICAL HISTORY

THE MORE INFORMATION WE HAVE, THE BETTER UNDERSTANDING WE WILL HAVE OF YOUR CHILD’S NEEDS.

Primary language: ________________________________
Additional medical problems (allergies, asthma, diabetes, etc.): ________________________________
Drug allergies: ________________________________
Dietary restrictions or food allergies: ________________________________
Physical limitations: ________________________________
Mobility (e.g., wheelchair, crutches, amputation): ________________________________
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 that would be helpful in our assessment: ________________________________

________________________________

(11/6/2017) 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 for a Family Sponsorship. 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.

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

<table>
<thead>
<tr>
<th>All Children’s Names</th>
<th>Date of Birth</th>
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<tbody>
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<td>7.</td>
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</table>

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, area hospitals, health care professionals 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 may be requested.

I understand that Camp Sunshine reserves the right to accept or decline any application for any reason.

Parent/Guardian/Other Adult ______________________________ Signature __________________________ Date __________

Parent/Guardian/Other Adult ______________________________ Signature __________________________ Date __________
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. Children should not attend camp if they are entering into an anticipated period of significant myelosuppression. We regret that we cannot accommodate patients with renal disease who are on hemodialysis.

2. Children 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 child’s attendance, noting up-to-date laboratory tests and medication changes.

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 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.

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 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 completed application to:
Camp Sunshine
35 Acadia Road
Casco, ME 04015

Phone: (207) 655-3800      Fax: (207) 655-3825
www.campsunshine.org
CAMP SUNSHINE RETINOBLASTOMA PHYSICAL EXAMINATION FORM

The following information should be provided by the pediatric ophthalmology or oncology team treating the child.

Please return to Camp Sunshine, 35 Acadia Road, Casco, Maine 04015
Telephone (207) 655-3800 Fax (207) 655-3825 E-mail info@campsunshine.org

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

Child’s Name: ______________________________ Date of Birth: _____ / _____ / _____
Diagnosis: __________________________________ Date of Diagnosis: _____ / _____ / _____
Allergies: __________________________________ Date of Examination: _____ / _____ / _____

1. Cancer/Hematologic Disease
   Is the child on active treatment?
   ☐ Yes: Date of most recent chemotherapy: _____ / _____ / _____ ☐ No: Date therapy completed: _____ / _____ / _____
   Describe any recent admissions or serious illnesses: ____________________________________________________________

2. Central Venous Access
   Type of access: ☐ External (Broviac/Hickman) ☐ Internal (Portacath/Infusaport/Mediport) ☐ Not applicable
   Special instructions regarding central line/port: ________________________________________________________________

3. Is the child Permitted to Participate in the Following Activities at Camp:
   Swim in a chlorinated indoor heated pool? ☐ Yes ☐ No Downhill ski or snowboard? ☐ Yes ☐ No
   Swim in lake water? ☐ Yes ☐ No Ice skating? ☐ Yes ☐ No
   Engage in contact sports? ☐ Yes ☐ No Sledding? ☐ Yes ☐ No
   Climb on our climbing wall? ☐ Yes ☐ No
   Participate in high elements on our ropes course? ☐ Yes ☐ No
   Are there any restrictions or suggestions for this child? _______________________________________________________
   Describe any disability or physical limitations affecting other camp activity: ___________________________________________

4. 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? ____________________________________________________________

5. 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? ____________________

6. Brain Tumor ☐ Not applicable
   Does the child have a VP shunt? ☐ Yes ☐ No
   Is it functioning? ☐ Yes ☐ No
   When was the last revision? ______________
   Does the child have seizures? ☐ Yes ☐ No
   What type and frequency? ________________________________
   Please describe any residual neurologic dysfunction: __________________________________________________________

7. 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
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 child require laboratory tests while at camp? If so, please specify which tests and to whom results should be mailed/faxed.
(Please limit these to essential studies.) ___________________________________________

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.

<table>
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<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
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*Each family should bring all medications, dressings, and other supplies necessary for their child while at camp.

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? ___________________________________________________________

We regret that applications cannot be reviewed unless the signature of the attending ophthalmology or oncology physician or certified nurse practitioner is provided below. Thank you.

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: (____) ___________________

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

Camp Sunshine
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: ______________

Relationship to camper ____________________ Parent/guardian (if applicable) ____________________

Name (in full) as you would like it to appear on the nametag ___________________________________________

Address ___________________________ City _______________________ State ________ Zip ________

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: ____________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
Camper’s name ______________________

Name __________________________

**Allergies**

Describe reaction and management of the reaction

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<th>Medication 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 ____________________________________________