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

2019 Shwachman-Diamond Syndrome Camp Information

Thank you for your interest in attending Camp Sunshine. Pages 1–3 of the application are for families to complete. Pages 4–6 are for your hematology/oncology or gastroenterology 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 the program, please call Camp Sunshine to inquire about availability.)
- Families may attend one session per program 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.
- You will be contacted once your receipt has been processed. 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

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2019 Shwachman-Diamond Syndrome Application Checklist

Please use to 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 Shwachman-Diamond syndrome. The Health History forms do not require a physician signature.

❑ Session Selection

- Please select three session dates per program year, 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

2019 Shwachman-Diamond Syndrome Program
Family Application

Please print clearly using black or blue ink.

SDS CAMPER INFORMATION

SDS Camper's Last Name ______________________ **SDS Camper's First Name** ________________
Gender _____________________________________ **Date of Birth** ______/_______/________
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 ____

2019 Session Dates

Please indicate your preferred session dates **(1-3)** below.
Family applications will be reviewed and accepted for one session per program year (April 2019 – February 2020)

☐	**May 30 – Jun 4, 2019**	**Mixed Diagnosis***	☐	**Aug 24 – 28, 2019**	**Mixed Diagnosis***
☐	**July 14 – 19, 2019**	**Hematology/ Oncology**	☐	**Oct 25 – 28, 2019**	**Mixed Diagnosis***

*Mixed Diagnosis Sessions: Families of children with any diagnosis served by Camp Sunshine are encouraged to apply

********************************FOR OFFICE USE ONLY********************************
❑ Family Forms ❑ Immunizations ❑ Physician Forms ❑ Health History Forms

INFORMATION FOR FAMILIES WITH CHILDREN UNDER AGE 18

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/Legal Guardian 1	Parent/Legal Guardian 2
Parent/Legal Guardian 1 ____________	Parent/Legal Guardian 2 ____________
Relationship to child ____________	Relationship to child____________
Date of Birth _____/_____/_______	Date of Birth ____/____/_______
Address ____________	Address ____________
City, State, Zip ____________	City, State, Zip ____________
Home Phone ____________	Home Phone ____________
Cellular phone ____________	Cellular phone ____________
E-mail ____________	E-mail ____________
Employer ____________	Employer ____________
Have you been in the Armed Forces? ❑ Yes ❑ No	Have you been in the Armed Forces? ❑ Yes ❑ No
Have you been in the Reserves? ❑ Yes ❑ No	Have you been in the Reserves? ❑ Yes ❑ No

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

Name ____________ Relationship ____________ Telephone ____________

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

Adult/Parents'/Legal Guardians'/ Support Person's Names	Relationship to camper	Medical or Emotional diagnosis/ concern? If "Yes," please explain and include on health history form
1. ____________	____________	❑ No ❑ Yes____________
2. ____________	____________	❑ No ❑ Yes____________

Sibling's/ Camper's Children/ 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
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 COURT DOCUMENTATION CONFIRMING THE GUARDIANSHIP MUST BE INCLUDED WITH THIS APPLICATION. IF MARITAL STATUS IS SEPARATED OR DIVORCED, PARENTS/LEGAL GUARDIANS MAY BE REQUIRED TO PROVIDE ADDITIONAL INFORMATION.**

SDS CAMPER'S GENERAL MEDICAL HISTORY

THE MORE INFORMATION WE HAVE, THE BETTER UNDERSTANDING WE WILL HAVE OF THE SDS CAMPER'S NEEDS.

Primary language: ____________ Secondary 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 the SDS 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 SDS camper incontinent? ❑ Yes ❑ No If yes: ❑ Bladder ❑ Bowel Is catheterization needed? ❑ Yes ❑ No

Please provide any additional information (developmental, social, behavioral) for consideration: ____________

____

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 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__________
(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 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__________
(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.

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

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

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, 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__________
(please print)

Parent/Guardian/Other Adult ____________________________ Signature ________________________ Date__________
(please print)

Physician Guidelines for Camp Sunshine

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

Phone: (207) 655-3800 Fax: (207) 655-3825
www.campsunshine.org

CAMP SUNSHINE SHWACHMAN-DIAMOND SYNDROME PHYSICAL EXAMINATION FORM

The following information must be provided by the pediatric hematology/oncology or gastroenterology team treating the patient.

Please return to Camp Sunshine: 35 Acadia Road, Casco, Maine 04015 P: (207) 655-3800 F: (207) 655-3825

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

SDS Patient's Name ____________________________ **Date of Birth:** ____ /____ /_____

Diagnosis: ________________________________ **Date of Diagnosis:** ____ /____ /_____

Allergies: ____________________________________ **Date of Examination:** ____ /____ /_____

❶ **Shwachman-Diamond syndrome**

Does the patient receive pancreatic enzyme replacement? ❑ Yes ❑ No If so, please specify ____________________________

Does the patient require colony stimulating factor? ❑ Yes ❑ No If so, please specify ____________________________

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 child: ____

❷ **Central venous access**

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

Special instructions regarding central line/port: ____

❸ **Is the Child Permitted to Participate in the Following Activities at Camp:**

Swim in a chlorinated indoor heated pool? ❑ Yes ❑ No

Swim in lake water? ❑ Yes ❑ No

Engage in contact sports? ❑ 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: ____________________________________

❹ **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? ____

❺ **Hematopoietic stem cell transplantation** ❑ Not applicable

Has the patient undergone stem cell transplantation? ❑ Bone marrow ❑ Peripheral stem cell ❑ Cord blood

Donor: ❑ Related ❑ Unrelated 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 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 CHILD REQUIRE VARIZIG AND/OR ACYCLOVIR? ❑ YES ❑ NO

❼ 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: ____

❽ 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.) ____

❾ 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 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 or gastroenterology physician, or certified specialty 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, LABORATORY RESULTS).** ☜

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: ___________________

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: _______________________________
____
____
____
____

(12/18/2018)

Camper's name _______________________

Name __________________________

Allergies	**Describe reaction and management of the reaction**
Medication allergies (list)	
___________________	____
___________________	____
___________________	____
___________________	____
Food allergies (list)	
___________________	____
___________________	____
___________________	____
___________________	____
Other allergies (list)	
___________________	____
___________________	____
___________________	____
___________________	____

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 ____

Printed Name ____ Date ____________