



Please return to:
2676 S. Vista Avenue
Boise, ID 83705
Fax: 208.343.9922

Thank you for your interest in our summer programs. Applications must be received no later than **April 7, 2010**. This deadline is imperative as it will allow us to have a sufficient amount of time to plan appropriately. Also, due to recent organizational growth, space will be limited for the first time in our twenty-five year history.

The enclosed applications are extensive and may seem a bit overwhelming. In an effort to meet national standards and to continue to provide quality services for our children and families, all of the materials are needed and must be completed each year. It is our policy that unfinished applications will not be accepted and your child will not be allowed to attend camp without a complete application on file. To ensure your child is invited to camp, please be aware of the following requirements for each of the applications:

- Applications must be notarized. We have a notary in our office that will be happy to help with this aspect of the process. Please call before coming to assure availability.
- The Consent for Medical/Surgical Care/Emergency Treatment/Medical Information must include a copy of both the front and back of your child's medical insurance card.
- The Physician's Form must be signed by a physician despite the fact that he/she may not be receiving treatment currently.
- Your child will not be released from camp until the individual picking him/her up provides proof of identity as listed on the application.

After your child's application is received and reviewed by our office, you will receive an all inclusive packet that will include details regarding pertinent information you need to be aware of as well as transportation particulars and a packing list for each camp.

If you have any questions or concerns about the application process or the camps in general, please contact us by calling 208-422-0176 or send an email to camp.rainbowgold@cancer.org. Thank you for your desire to participate in camp and we look forward to a great summer.

**All forms are due no later than Wednesday, April 7, 2010
however the sooner we receive them the better!**

Oncology Camp Application 2010

Please return to:
2676 S. Vista Avenue
Boise, ID 83705
Fax: 208.343.9922

Camper's Personal Information

Child's full name: _____

Name child prefers to be called: _____ Male _____ Female

Address: _____

City: _____ State: _____ Zip code: _____

Telephone: Home: (____) _____ Birth date: _____

Grade in school next fall: _____ Age child will be during camp: _____

T-shirt size: (Youth Size) S M L XL _____ Female Cut _____ Male Cut

(Adult Size) S M L XL XXL _____ Female Cut _____ Male Cut

Has your child ever been to camp before? Yes _____ No _____ Overnight camp? Yes _____ No _____

Father's name _____

Email address: _____

Address (if different than child's): _____

City: _____ State: _____ Zip code: _____

Telephone: Home: (____) _____ Cell: (____) _____

Mother's name _____

Email address: _____

Address (if different than child's): _____

City: _____ State: _____ Zip code: _____

Telephone: Home: (____) _____ Cell: (____) _____

Emergency contact (if parent /guardian cannot be reached)

Full Name: _____

Telephone: Home: (____) _____ Cell: (____) _____

Relationship to child: _____

Medical Information

Cancer diagnosis: _____

Date of diagnosis: _____

Name of family physician: _____

Emergency telephone: (____) _____

Name of oncologist: _____

Emergency telephone: (____) _____

Name of dentist: _____

Emergency telephone: (____) _____

Any other physicians or health care providers we need to be aware of:

Does your child have any of the following?

Asthma

Diabetes

Seizures

Poor vision

Poor hearing

Loss of balance and/or coordination

Other _____

Please advise us how we can be of help to your child:

Does your child have challenges related to any of the following:

Sleep walking

Bed wetting

Using the restroom

Constipation

Bathing or brushing

Getting dressed

Eating

Other _____

Please advise us how we can be of help to your child:

Does your child experience challenges in any of the following areas?

Participating in group functions/settings

Following instructions

Paying attention

Please advise us how we can be of help to your child:

Immunization Information

Please attach a copy of your child's immunization records.

Medication Administration

Does your child swallow pills?

Yes _____ No _____

Please describe the routine you and your child go through when administering medications:

Please advise us of any special foods or fluids that are given with medications:

For female children only:

Has your child began menstruating yet? Yes _____ No _____
If no, is she informed about it? Yes _____ No _____
If yes, is her menstrual history normal? Yes _____ No _____

Additional Information

Camp policy does not allow lake swimming for children with Broviac/Hickman catheters or any person who has undergone surgery within the last seven days. Patients with a port may swim unless accessed within the previous day.

Does your child have permission to swim? Yes _____ No _____
Does your child know how to swim? Yes _____ No _____
Does your child require help while in the water? Yes _____ No _____

Many activities will be available during the week. Does your child have permission to do any/all of the following?

Horseback riding Yes _____ No _____
Mountain biking Yes _____ No _____
Hiking Yes _____ No _____
Water skiing Yes _____ No _____
Ice skating Yes _____ No _____
White water rafting Yes _____ No _____
Rock wall climbing Yes _____ No _____

Please describe any activities that you wish to be restricted to your child:

The more information we have on your child, the better we will be able to care for him/her! Please provide us with anything else you believe we should know about your child that will smooth his/her adjustment:

Please describe any personality issues, parental concerns and/or child fears and include your recommendations:

Transportation Information

Child's name: _____

Age during camp: _____

My child will be **arriving to camp** via:

Boise bus (free transportation leaving from the American Cancer Society office)

Personal vehicle

Name of driver: _____

Other _____

I wish to set up a car pool arrangement with other parents

I need Angel Flight arrangements

My child will be **departing camp** via:

Boise bus

Personal vehicle

Name of driver: _____

Other _____

I wish to set up a car pool arrangement with other parents

I need Angel Flight arrangements

Campers will be released only to those individuals listed below, upon proof of identity (i.e., valid driver's license or government issued picture identification). This includes parent(s) and/or guardian(s).

1. _____
Name Address Telephone

2. _____
Name Address Telephone

3. _____
Name Address Telephone

Parent/legal guardian signature

Date

Consent Agreement, Authorization and Release

I hereby request and consent that my child or ward named below be permitted to travel to and from and participate in the American Cancer Society's Oncology Teen Camp (ages 13-17yrs) on the dates of July 25 through July 20, 2010 or Oncology Youth Camp (ages 6 through 12yrs), on the dates of August 1 through August 6, 2010.

Child's full name: _____ Telephone: (____) _____

Consent for Media

The nature of the American Cancer Society's Camp Rainbow Gold activities has been reviewed with me, and I hereby give my approval. I further grant permission for the child named above, to appear in person or in voice, video or photographic presentation for radio, television, internet, or print media reports and/or media campaign(s) resulting from participation in the American Cancer Society's Camp Rainbow Gold activities throughout the year.

Consent for Camp Directory

I give _____ do not give _____ Camp Rainbow Gold permission to publish the child named above contact information in the annual Camp Rainbow Gold directory that will be released to all campers and volunteers at camp.

Release of Liability

I agree to and understand the following: My child or ward may be accompanied and transported by American Cancer Society (ACS) and/or officials sponsoring the Camp Center of Excellence Camp to and from Camp Activities. I agree and acknowledge, however, that neither ACS, nor its employees, agents, or volunteers assume any liability whatsoever by such accompaniment or transportation.

I agree that neither ACS, nor its employees, agents, or volunteers associated with the ACS Camp Center of Excellence Camp and/or Camp Rainbow Gold activities shall be held responsible for any injuries or damages that occur while my child is traveling to or from such ACS Camp Center of Excellence Camp and/or Camp Rainbow Gold activities or during the time my child is in attendance at or is participating in the ACS Camp Center of Excellence Camp and/or Camp Rainbow Gold activities. I do hereby hold harmless ACS, its employees, agents, and volunteers against any and all liability, damage, loss, claims or demands which arise out of or are in any way connected with my child or ward's travel to and from, attendance at or participation in the ACS Camp Center of Excellence Camp and/or Camp Rainbow Gold. I hereby authorize any ACS employee, agent, volunteer, or designated chaperone to consent to emergency medical treatment as necessary for the health and safety of my child. I further agree that no ACS employee, agent, volunteer, or designated chaperone will be held responsible for injuries or damages arising from the provision of any such emergency medical treatment. I also authorize the treating medical institution and/or medical providers to hospitalize and administer the appropriate treatment deemed medically necessary for my child. I do hereby agree to indemnify and hold harmless ACS and any ACS employee, agent, volunteer, or designated chaperone from any and all liability, damage, loss, claims, or demands and actions of any nature whatsoever, including attorneys' fees, which arise out of or are in any way connected with the provision of such emergency medical services.

Camper signature if over the age of 18: _____

Parent/guardian signature: _____

Date: _____

Notary

For your child to be accepted as a camper, please sign these forms in the presence of a notary and have him/her notarize this document.

Parent/guardian signature: _____

Date: _____

STATE OF IDAHO)
)ss.
County of Ada)

SUBSCRIBED AND SWORN before me this _____ day of _____, 2010 by

_____.

Name: _____
Notary Public for Idaho
Residing at: _____
My commission expires: _____

**Consent for Medical/Surgical
Care/Emergency Treatment/Medical Information**

Please attach a copy of your insurance card.

Child's full name: _____ Telephone: (____) _____

Date of Birth: _____ Male _____ Female _____

In presenting my son/daughter for diagnosis and treatment I _____,
_____ mother _____ father _____ legal guardian

As the parent/legal guardian of the above named child, I give full authorization to the American Cancer Society staff or agents to secure medical care or treatment for said youth. This treatment may include assistance from the nearest physician, medical clinic, hospital, trained nurse or EMT in the event of illness or injury that requires immediate attention, as determined by the ACS Camp Rainbow Gold staff. In the event that I cannot be contacted, and an emergency has occurred, I give permission to the treating medical institution and/or medical providers to hospitalize and administer the appropriate treatment deemed medically necessary for my child.

My child has the following health issues and/or problems: _____

My child takes the following prescription and/or non-prescription medications: _____

My child has the following allergies (including food, medication and all other allergies): _____

My child does not have health insurance coverage: _____ (please initial)

Name of health insurance carrier: _____

Address: _____ City: _____ State: _____

Zip code: _____ Telephone: (____) _____

Name of policy holder: _____

Policy number: _____ Group number: _____

Parent/guardian signature

Date

Physician's Form

This form must accompany the application and needs to be signed by a physician.

Name of child: _____

Birth date: _____ Male/female: _____

Height: _____ Weight: _____

Temperature: _____ Pulse: _____ Blood pressure: _____ Respiratory rate: _____

Allergies: _____

Primary oncology diagnosis: _____

Secondary diagnosis: _____

Is this child on treatment? _____ When was treatment complete? _____

Administer tetanus IM if indicated? _____ Varicella history? _____

Do you anticipate anemia, neutropenia or thrombocytopenia during camp? _____

Any specific orders for camp? _____

Does the child have physical limitations? _____

Does the child need one on one assistance? _____

Does the child have dietary restrictions? _____

Does the child have any of the following?

IV _____ Shunt _____ Feeding tube _____ Prosthesis _____ Walker _____

Wheelchair _____ Other _____

Does the child have any of the following activity restrictions? (check to ban)

Swimming _____ Biking _____ Rafting _____ Ice skating _____

Rock Wall _____ Horseback riding _____ Other _____

Medication: (name and signature)

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Printed physician's name: _____

Office telephone: (____) _____

Office address: _____

Physician's signature: _____

Date: _____

Permission to Treat and Administer Medications

Child's name: _____

Age: _____ Date of birth: _____

The undersigned hereby grants permission to the medical staff or consulting physicians with the Camp Rainbow Gold program to provide routine health care; to administer medications; to order x-rays and other diagnostic tests; treatment and to release any records necessary for insurance purposes.

Medications to be Administered at Camp

| Medication and strength: | Route: | Dose: | Time: | Special instructions: |
|--------------------------|--------|-------|-------|-----------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

List allergies and reactions:

1. Medication must be brought to camp in the **original container with appropriate label intact.**
2. Medication will be stored in the med shack.
3. Parent/guardian must sign this form granting permission to administer medication.

The medical staff or consulting physicians with the Camp Rainbow Gold program has my permission to administer the above medication(s) to my child as prescribed. I also give my permission for the prescribing physician/dentist to be contacted, if necessary, regarding the medication(s) or health concerns.

I also hereby give permission for Camp Rainbow Gold to administer over-the-counter medications if deemed necessary by the nurse or physician on duty in the med shack. Dosages will be administered according to directions on the bottle unless a physician or nurse practitioner directs otherwise. Examples of over the counter medications may include: antipyretics/analgesics (e.g. Ibuprophen, acetaminophen), antihistamines (e.g. Benadryl®), antidiarrhea (e.g. Immodium®, Pepto Bismol®), constipation (e.g. senna), topical skin treatments (e.g. calamine lotion, hydrocortisone, antibiotic ointment). The med shack will also have the prescription medication epinephrine available to be administered for life-threatening allergic reactions.

Signature of parent/guardian

Date

Daytime telephone number

Request for Protected Health Information

Camper: _____ Date of Birth: _____

Address: _____ Phone: _____

Other names under which camper has been treated: _____

At anytime **or** Dates of service: From _____ to _____

This is to authorize: _____

Facility and any of their affiliated entities, employees, agents, or associated health care practitioners to disclose the camper's protected health information to:

SEND TO: Camp Rainbow Gold
2676 S Vista Ave
Boise, ID 83705
208.422.0174 (office)
208.343.9922 (fax)

Medical Records Requested:

- | | |
|---|---|
| <input type="checkbox"/> Any information concerning the camper's health or health care | <input type="checkbox"/> History and physical |
| <input type="checkbox"/> AIDS diagnosis and/or positive HIV tests Patient must initial _____ to be valid | <input type="checkbox"/> Laboratory reports |
| <input type="checkbox"/> Alcohol or drug abuse records Patient must initial _____ to be valid | <input type="checkbox"/> Operative report |
| <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Outpatient surgery |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Pathology reports |
| <input type="checkbox"/> X-ray films / reports | <input type="checkbox"/> Physician's order and progress notes |
| <input type="checkbox"/> EKG / cardiac monitoring | <input type="checkbox"/> Other: _____ |

I understand that I have the right to revoke this authorization at anytime except to the extent that the above named facility has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to the American Cancer Society's Director of Children and Family Services.

I understand that information disclosed by this authorization may be re-disclosed by Camp Rainbow Gold and may no longer be protected by privacy regulations.

This authorization will expire on the following date of event: _____. If no specific date of event is stated, this authorization will expire one (1) year from the date of this authorization

Signature of Parent/Guardian

Date

Authority or Relationship to the Camper

Oncology Camp Application Checklist

Please return to:
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Did you forget anything? Please note that ALL of the following must be included with the submission of your child's application.

- ✓ Notary's signature
- ✓ Copies of all health insurance cards, front and back
- ✓ Physician Form completed and signed by appropriate medical personnel
- ✓ Consent for Medical Care Form completed and signed
- ✓ Transportation section filled out completely
- ✓ Release section filled out completely
- ✓ Request for Medical Health Information completed and signed

Please feel free to contact us at 208-422-0176 or send and email to camp.rainbowgold@cancer.org

www.camprainbowgold.org