SICKLE CELL SUPPORT SERVICES
SUMMER ENRICHMENT CAMP

P.O. BOX 4186, Little Rock AR 72214
(501)650-0764 Fax (501)897-0509

Please check one for type of camper: _____sibling _____ sickle cell disease

CAMPER APPLICATION

****PLEASE NOTE: COMPLETED APPLICATIONS ARE APPROVED ON A FIRST COME, FIRST SERVED BASIS. TO ASSURE YOUR RESERVATION, SEND YOUR COMPLETED APPLICATION IN AS SOON AS POSSIBLE.***

PLEASE PRINT OR TYPE APPLICATION **DATE ____________________________**

NAME ____ AGE ________ SEX _________
LAST FIRST MIDDLE

ADDRESS____
STREET CITY STATE ZIP

TELEPHONE ( ) __________________________ DATE OF BIRTH ____

COUNTY OF RESIDENCE ____ RACE ___________________________

HIGHEST GRADE COMPLETED ____

PARENT/LEGAL GUARDIAN ____

PHONE: HOME ( ) _____________________________________ WORK ( )________________________________

ADDRESS____
STREET CITY STATE ZIP

PERSON TO BE NOTIFIED IN AN EMERGENCY IF PARENT/GUARDIAN CANNOT BE REACHED:

NAME ____ RELATIONSHIP ____________________________

PHONE ( ) ____

HEALTH INSURANCE INFORMATION:

COMPANY ____ POLICY NUMBER ____________________________

MEDICARE NUMBER ___________________________________ MEDICAID NUMBER__________________________

TRANSPORTATION TO & FROM CAMP PROVIDED BY ____

IF A REQUEST FOR CAR POOLING IS RECEIVED, MAY WE GIVE YOUR NAME & PHONE NUMBER TO OTHERS?___________

HAVE YOU ATTENDED SICKLE CELL SUMMER ENRICHMENT CAMP BEFORE? ________WHEN? __________

HOW DID YOU FIND OUT ABOUT SICKLE CELL SUMMER ENRICHMENT CAMP?

____

____

SICKLE CELL SUPPORT SERVICES
SUMMER ENRICHMENT CAMP 2012

IMPORTANT NOTE: THE NEXT 3 SECTIONS MUST BE SIGNED BY PARENT, OR GUARDIAN.

APPLICANT'S NAME _______________________________________ DATE __________

RELEASE OF INFORMATION: I hereby give permission to Sickle Cell Support Services (SCSS) to release or receive information, on the applicant named above, to and from other related professionals and agencies, as necessary for the purpose of serving the client, and with the understanding that such information will be held confidential. I also give permission for SCSS to gather information for the purposes of evaluating the camp experience for above named child. Failure to complete this information will have no bearing on my child attending camp.

____
Signature of Parent/Guardian

Witness ____ Date ________________________________

CAMP ATTENDANCE RELEASE: I hereby give permission for the applicant as named above to attend Sickle Cell Summer Enrichment Camp at 4H Camp.

In consideration for the acceptance of the above named, I/we hereby release any claim or cause of action which may accrue against the SCSS and/or 4H Camp, and any employee or either one and any other person acting with the permission of either, arising out of any injury acquired during his/her stay at the camp, in transit to and from said camp, or during any activity approved by any of said persons. I/we agree to assume any claim which said child in his/her personal capacity might have against any of said persons for injury as herein stated.

____
Signature of Parent/Guardian

Witness ____ Date ________________________________

PHOTO RELEASE: I consent to the use and publication by SCSS and/or 4H Camp, its affiliates or others with its consent, of any photographs, negatives, prints, motions pictures, video tapes, or other similar reproductions obtained of the applicant as named above while participating in any camping activity through any medium of communication.

____
Signature of Parent/Guardian

Witness ____ Date ________________________________

HEALTH HISTORY/EMERGENCY TREATMENT RELEASE
To be completed by parent or guardian

PLEASE ANSWER ALL QUESTIONS:

Camper Name ____ **Birth Date** ________________________

Sex __________ **Age** ________ **Hemoglobin Type:** _____ **SS** _____ **SC** _____ **S-Thal** ________ **Other**

Parent or Guardian ____ **Phone** ______________________

Home Address ____

Parent or Guardian place of employment ____

Address ____ **Phone** ______________________

If not available in an emergency, notify: ____

Name ____ **Phone**______________________

Address ____

PLEASE CIRCLE ANSWER:

1. **Does camper have cardiac condition?** **Yes** **No**

   List care and limitations ____
   ____

2. **Does camper have seizures?** **Yes** **No**

   Type **Frequency** **Date of last seizures**
   ____
   ____

3. **Is camper diabetic?** **Yes** **No**

4. **Does camper have asthma?** **Yes** **No**

5. **Does camper require a special diet?** **Yes** **No**
   If yes, please attach copy of diet.

6. **Should camper be restricted from the following activities:**

   Swimming **Yes** **No**

   If yes, please explain: ____
   ____

   Other ____
   ____

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7. Does camper have history of any of the following? If yes, please include date of last occurrence:

Ear Infection __________________________
Convulsions ___________________________
Bleeding/Clotting Disorders _____________
Mononucleosis ________________________
Hypertension ________________________
Rheumatic Fever ____________________
Psychiatric Treatment ________________

ALLERGIES

Hay Fever _____________________________
Insect Stings ___________________________
Other Drugs ___________________________
Poison Ivy, etc. ________________________
Penicillin ______________________________
Asthma ________________________________

DISEASES OR IMMUNIZATION FOR DISEASE:**
(Please state date of immunization or date of disease)

Chicken Pox ___________________________
German Measles ______________________
Measles ________________________________
Mumps _________________________________
Operations or recurring illness, please specify: ____

____

*****If physician does not have record of vaccinations or disease, parent or guardian must provide. This is a must for approval to attend camp. (See question 15 on Medical Examination Form).*****

Does camper take medications? Please list name of medicine, dose and time schedule:

Medicine	Dosage	Time Schedule

PLEASE SEND ADEQUATE SUPPLY OF MEDICINE FOR ENTIRE SESSION. (All medications MUST be in pharmacy labeled bottles. One bottle per medication. DO NOT MIX MEDICATIONS IN SAME BOTTLE.

EMERGENCY TREATMENT RELEASE:

Name of Camper: ____

This health history is correct as far as I know, and the above named person has permission to engage in all prescribed camp activities except where noted. I hereby give permission to the camp:

1. **To provide ongoing health care**
2. **To select medical personnel and to order x-rays or routine tests or treatment for the camper.**

In the event I cannot be reached in an emergency, I hereby give permission to the appointed medical director or camp physician to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the above named person. This form may be photocopied for use out of camp.

____
Signature of parent/guardian **Date**

SICKLE CELL SUPPORT SERVICES
SUMMER ENRICHMENT CAMP 2010
P.O. BOX 4186, Little Rock AR 72214
(501)590-6943 Fax (501)897-0509

CAMP HEALTH FORM

Note: This form must be completed by a physician prior to attendance to camp. Campers must have a physical examination within 6 months prior to the camp session.

NAME: ____ ***DOB:*** _____________ ***DATE:*** ___________

Immunization History	*Year primary series completed*	*Year of last booster*
DPT (Diphtheria, Pertussis, Whooping Cough, Tetanus)	______________________	______________________
Oral Polio	______________________	______________________
D. T. (Diphtheria, Tetanus)	______________________	______________________
Tetanus (Within 10 years)	______________________	______________________
Measles	______________________	______________________
Mumps	______________________	______________________
Rubella (German Measles)	______________________	______________________
Hb PV	______________________	______________________
HIB	______________________	______________________
Tuberculin Skin Test (within 1 year)	*Date:* ____________________	*Results: ( )negative ( ) positive*
and/or Chest X-Ray	*Date:* ____________________	*Results: ( )negative ( ) positive*

Date of Physical (within 6 months of camp session)____
Codes: ***1 (satisfactory)*** ***x (not satisfactory)*** ***0 (not examined)***

Height _________ ***Weight*** _____________ ***Blood Pressure*** _______________ ***TPR*** ________________________

Hemoglobin Type: ______ ***General Appearance*** ____________ ***Nutritional Status*** ________________________

Vision: ***(without Glasses R:*** ___ ***L:*** ___***)*** ***(with Glasses R:*** ____ ***L:*** ____ ***)***
Ears: ***(Hearing R:*** ___________ ***L:*** ______________***)***

Teeth __________________________________
Nose __________________________________
Throat __________________________________
Lungs __________________________________
Heart __________________________________
Abdomen ________________________________
Date of Menarche__________________________
(if applicable)

Genitalia: ____________________________________
Skin: ____
Musculoskeletal: ______________________________
Urinalysis: ___________________________________
Hemoglobin: __________________________________
Baseline Hgb: ________________________________
Other Notes ___________________________________

Does applicant require specialized treatment or assistance (i.e., home health agency, oxygen therapy) during camp experience? Explain.____
____

Please list all medications to be administered during camp.

Name of Drug	*Dosage*	*Frequency*

This person is in satisfactory condition and may engage in all usual camp activities except as noted.

Physician's Name (Type or Print)____________________________________***Date***_____________________________

Physician's Signature____

Address __________________________***City*** ______________________ ***State*** _____ ***Zip*** ________ ***Phone*** __________