



Dear Parent:

Thank you for your interest in **CCFA Camp Oasis**, located in Butler County, OH.

The 2005 Camp Session will be held June 8 – 12, 2005.

As the name suggests, CCFA Camp Oasis provides children with Crohn's disease and ulcerative colitis a safe natural environment – away from the burdens of their daily life – where they can meet new friends, try new things, and above all **HAVE FUN!**

Before your child can be considered for acceptance at CCFA Camp Oasis, the following forms must be completed and signed by the designated individuals. Once all of the required forms have been received, the Camp Director and Medical Director will review them and inform you of the decision.

Completed forms should be sent together in one mailing to the address listed below.

CCFA - Southwest Ohio Chapter
8 Triangle Park Drive, Suite 800, Cincinnati, Ohio 45246
Phone: (513) 772-3550 or (877) 283-7513
E-mail: nbalster@ccfa.org

If you have any questions, please contact the office listed above.

Again, thanks for your interest in CCFA Camp Oasis. We look forward to the opportunity to work with your child.

Sincerely,
CCFA Camp Oasis Directors



2005 Camper Application

FOR OFFICE USE ONLY

Application Checklist: Check When Completed
 Camper Application; Date: _____
 Medical Application Package; Date: _____
 General Authorization Form; Date: _____

Camp Director _____ Medical Director _____
 Date Reviewed: ____ Date Reviewed: ____
 ACC / DEC ACC / DEC

FINAL: ACC / DEC

To BE COMPLETED BY PARENT OR GUARDIAN

Camper's full name: _____ Nickname: _____

Age: _____ Birth date: _____ Male Female Current grade in school: _____

Street address: _____

City: _____ State: _____ Zip: _____ County: _____

Mailing address (if different): _____

City: _____ State: _____ Zip: _____

Home phone: _____ Email address: _____

Camper's primary language: English Spanish Other (please specify): _____

Does camper speak English? Yes No

Camper's Shirt Size: _____ Camper's Pant Size: _____

Parent / Legal Guardian

Full name: _____

Address: _____

Home phone: _____ Cell phone: _____

Employer's name: _____ Work phone: _____

Email address: _____

Relationship to camper: Mother Father Other (please specify): _____

Parent / Legal Guardian

Full name: _____

Address: _____

Home phone: _____ Cell phone: _____

Employer's name: _____ Work phone: _____

Email address: _____

Relationship to camper: Mother Father Other (please specify): _____

With whom does the camper reside? (please check all that apply)

Mother Father Stepmother Stepfather Grandmother Grandfather

Sister(s): How many: _____ Brother(s): How many: _____ Other: _____

If parents are divorced or separated, who has legal custody? _____

Camper Name: _____ DOB: _____

Emergency Contact Information

I authorize the following person(s) to be contacted and give my permission to Camp Oasis to turn my child over to this person(s) if for any reason my child has to leave camp and I cannot be reached.

Full name: _____

Address: _____

Phone: _____ Alternate phone: _____

Relationship to camper: _____

Full name: _____

Address: _____

Phone: _____ Alternate phone: _____

Relationship to camper: _____

Insurance Information

NOTE: Please include a copy of the insurance card.

Insurance company: _____

Address: _____

Contact number: _____ Policy/Group number: _____

Name of insured: _____ Relationship to camper: _____

CCS number (if applicable): _____ Medi-Cal number (if applicable): _____

List any specific billing information: _____

Pediatrician's Information

Pediatrician's name: _____

Address: _____

Phone: _____ Emergency phone: _____

Pager: _____ Email address: _____

Gastroenterologist's Information

Gastroenterologist's name: _____ Hospital: _____

Address: _____

Phone: _____ Emergency phone: _____

Pager: _____ Email address: _____

Additional Contact Information

Additional doctor's name: _____ Phone: _____

Dentist's name: _____ Phone: _____

Social worker's name: _____ Phone: _____

Therapist's name: _____ Phone: _____

Camper Name: _____ DOB: _____

General Medical Information
(To be completed by parent/legal guardian)

Medical History

Diagnosis: _____ Date of diagnosis: _____

Please describe the symptoms your child has due to his/her medical condition:

Last doctor/ER visit date: _____ Reason: _____

Last hospitalization date: _____ Reason: _____

Last surgery date: _____ Reason: _____

Please check any other medical conditions that your child has:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> rashes | <input type="checkbox"/> vision loss | <input type="checkbox"/> hearing loss | <input type="checkbox"/> incontinence |
| <input type="checkbox"/> strep throat | <input type="checkbox"/> palpitations | <input type="checkbox"/> earaches | <input type="checkbox"/> bed wetting |
| <input type="checkbox"/> sinusitis | <input type="checkbox"/> arthritis | <input type="checkbox"/> PE tubes | <input type="checkbox"/> urinary tract infections |
| <input type="checkbox"/> headaches | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> hearing aid(s) | <input type="checkbox"/> kidney infection |
| <input type="checkbox"/> stomach aches | <input type="checkbox"/> depression | <input type="checkbox"/> nightmares | <input type="checkbox"/> constipation |
| <input type="checkbox"/> fainting episodes | <input type="checkbox"/> hay fever | <input type="checkbox"/> night terrors | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> hypertension | <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> sleepwalking | <input type="checkbox"/> immunodeficiency |
- asthma *Please specify severity:* Mild Moderate Severe
- Seizure(s) If yes, date of last seizure: _____
- Other(s) Please specify: _____

Comments regarding all of the checked medical conditions:

- If female, has your child begun her menstrual cycle? Yes No
- Will she have her period while at camp? Yes No
- Does she require pain medication during her period? Yes No If so what? _____

Comments:

Health Profile

In the past 12 months, on average, your child has had how many:

Clinic visits: _____ ER visits: _____

Hospitalizations: _____ Missed school days: _____

Camper Name: _____ DOB: _____

Immunization Dates

NOTE: Please complete or attach a copy of immunizations.

DTaP/DT: _____	MMR: _____
Date of Last Tetanus Booster: _____	Hepatitis B: _____
Polio (IPV/OPV): _____	HIB/H.Flue Vaccine: _____
Varivax: _____	Pneumoccal (PCV, Prevnar, Pneumovax) _____
Other: _____ Date: _____	
Has he/she had chicken pox? <input type="checkbox"/> Yes Date: _____ <input type="checkbox"/> No	
Was this diagnosed by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Special Medical Needs

Does your child have an implantable device/pacemaker? Yes No

Does your child have a central line/portacath? Yes No

Does your child have any devices/anatomy that require special care?
(ostomy, G-tube, J pouch, fistula, etc.) Yes No

If yes to any of the above, please specify and describe care needed:

Does your child require catheterization? Yes No

Does your child self-catheterize? Yes No

Please describe site, frequency, and routine care:

Camper Name: _____ DOB: _____

Food/Nutrition

Please list any food restrictions or special dietary requirements:

Allergies

Please list any *allergies to medication* (penicillin, etc.):

Please describe reaction:

Please list any *food allergies*:

Please describe reaction:

Please list any *additional allergies* (bee stings, horses, pollen, latex, dust mites, etc.):

Please describe reaction:

Family History

Please check if anyone in your immediate family has:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> diabetes | <input type="checkbox"/> cancer | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> heart disease |
| <input type="checkbox"/> thyroid disease | <input type="checkbox"/> seizures | <input type="checkbox"/> kidney disease | <input type="checkbox"/> HIV (optional) |
| <input type="checkbox"/> tuberculosis | If so, is this person on current treatment for TB? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Does anyone in the household smoke? Yes No

Camper Name: _____ DOB: _____

Camp Activity Profile

The following is a list of activities offered by CCFA Camp Oasis. If for medical reasons your child is unable to participate in any of the activities listed, please check below and explain in the area provided:

Program Areas

- | | |
|--|---|
| <input type="checkbox"/> arts and crafts | <input type="checkbox"/> ropes course |
| <input type="checkbox"/> baking | <input type="checkbox"/> sports and recreation |
| <input type="checkbox"/> boating and fishing | <input type="checkbox"/> swimming pool |
| <input type="checkbox"/> creative arts (creative writing, photography) | <input type="checkbox"/> woodworking |
| <input type="checkbox"/> discovery (science and nature) | <input type="checkbox"/> performing arts (theater, music, dance, clowning, magic) |
| <input type="checkbox"/> gardening | |
| <input type="checkbox"/> horseback riding | |
| <input type="checkbox"/> outdoor camping | |

Comments:

Please describe any other activity restrictions or precautions:

Please list any other activities your child enjoys:

- Can your child swim? Yes No
If yes, what level? beginner intermediate advanced
- May your child participate in supervised pool activities? Yes No
- Can your child walk up and down a flight of steps unassisted? Yes No
- Can your child walk at least ¼ - ½ mile unassisted several times daily? Yes No
- Does your child use any supportive devices? (If yes, please specify below) Yes No
- wheelchair crutches splints

Please describe use:

- brace(s) artificial limb(s) other: _____

Please specify the level of assistance your child requires:

	Independent	Close Supervision	Moderate Assistance	Total Care
Daily care (dressing, brushing teeth, combing hair)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing/showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting/bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Camper Name: _____ DOB: _____



2005 PHYSICIAN FORM

MUST BE COMPLETED & SIGNED BY LICENSED GASTROENTEROLOGIST

Date of Most Recent Exam: _____

IBD Diagnosis: _____ **Extent/Location:** _____

Symptom(s) present during a "flare": _____

Significant Events: *(Please check all items that the individual has/has had.)*

- Surgery (what/when? _____)
- ER visits this year (why/when? _____)
- J-pouch
- Ostomy
- Other diversionary appliance: _____
- Other: _____

Extraintestinal Manifestations: *(Please check all items that apply.)*

- Fevers (> 38 C or 100 F)
- Mouth sores
- Joints (arthritis/arhralgia)
- Skin (E. nodosum/P. gangrenosum)
- Eyes (uveitis)
- Perianal disease (tag/fissure/fistula)
- Sclerosing chol.
- Headaches

Abdominal Pain: Mild/Week Moderate/Week Severe/Week

Growth: Acute Weight Loss Chronic Growth Failure

Stools: ___/Day; ___/Week Form Semi Loose

Blood Mucus Nocturnal

PCDAI Score: _____ **CDAI Score:** _____

General Health Assessment

	Normal	Abnormal	Comments
EENT			
Neck			
Lungs			
Heart			
Abdomen			
Anus/Rectum			
Muscular/Skeletal			
Psych			
Lymph			
Neuro			
Skin			
Other			

Camper Name: _____ DOB: _____



MUST BE COMPLETED & SIGNED BY A LICENSED GASTROENTEROLOGIST

I hereby certify that I conducted a physical exam on _____ within the current year of 2005. (camper's name)

I understand that the above individual is seeking to participate in a special overnight camp for kids with inflammatory bowel disease, sponsored by the Crohn's & Colitis Foundation of America (CCFA).

I understand that a CCFA-provided physician(s) (*including a gastroenterologist*) and nursing team will be on-duty throughout the entire duration of camp. This team will be responsible for dispensing medication and providing direct medical care as needed.

I understand that CCFA will also have an on-call mental health professional that can provide support.

Physical Capabilities

Based on this information, do you **AGREE** or **DISAGREE** that the above listed camper is physically capable of participating in a weeklong summer camp that will include mild physical exertion in the form of walking in mildly hilly terrain and participating in athletics, swimming, tubing and other typical camp activities? (Note: There is a space at the end of this page to give specific details regarding the camper's limitations/restrictions of camp activities.)

If disagree, please explain: _____

Emotional Capabilities

Based on this information, do you **AGREE** or **DISAGREE** that the above listed camper is socially and emotionally capable of living in a communal environment with other same-age, same-sex children, supervised by a minimum of two adult counselors? (Note: There is a separate form to make comments on the camper's emotional/mental health issues.)

If disagree, please explain: _____

Overall Capabilities

Based on all of this information and your collective work with the above listed camper, do you believe that CCFA should **ACCEPT** or **DECLINE** this camper's application?

If **DECLINE**, please explain: _____

If **ACCEPT**, list any **limitations/restrictions** of camp activities: _____

Signature of Gastroenterologist: _____ Date: _____
Printed Name: _____ Address: _____
Phone: _____ Fax: _____

Camper Name: _____ DOB: _____



 **2005 MENTAL HEALTH FORM** 

MUST BE COMPLETED & SIGNED BY PARENT OR GUARDIAN

Does your child have any known emotional or mental health problems?

- No (No further information needs to be completed on this form.)
- Yes (Please have your child's mental health professional complete the information below.)

Parent/Guardian Name: _____

Signature: _____ Date: _____

MUST BE COMPLETED & SIGNED BY LICENSED MENTAL HEALTH PROFESSIONAL

Date of Most Recent Visit: _____

Mental Health Diagnosis: _____

Frequency of Treatment Visits: _____

Manifestations that may appear at camp: _____

Does this child pose a risk to him/herself or others? No Yes



If yes, please explain: _____

Please list any essential medications: _____

Additional Comments (please see next page): _____

Camper Name: _____ DOB: _____



 **2005 MENTAL HEALTH FORM** 

MUST BE COMPLETED & SIGNED BY LICENSED MENTAL HEALTH PROFESSIONAL

I hereby certify that I have provided mental health services to _____ within the past 12 months. (camper's name)

I understand that the above individual is seeking to participate in a special overnight camp for kids with inflammatory bowel disease, sponsored by the Crohn's & Colitis Foundation of America (CCFA).

I understand that a CCFA-provided physician(s) (*including a gastroenterologist*) and nursing team will be on-duty throughout the entire duration of camp. This team will be responsible for dispensing medication and providing direct medical care as needed.

I understand that CCFA will also have an on-call mental health professional that can provide support.

Based on this information, I believe CCFA should **ACCEPT** or **DECLINE** this camper's application.

If **DECLINE**, please explain: _____

If **ACCEPT**, list any **limitations/restrictions** of camp activities: _____

<p>Signature of Mental Health Professional: _____ Date: _____</p> <p>Printed Name: _____ Address: _____</p> <p>Phone: _____ Fax: _____</p> <p>24-Hour Emergency Phone Number: _____</p>
--

Camper Name: _____ DOB: _____



2005 MEDICATION DISTRIBUTION FORM

MUST BE SIGNED BY PARENT/GUARDIAN & LICENSED MD, LPN, OR PHYSICIAN'S ASSISTANT

Oral Medications

Drug Name and Strength	Dose	Frequency	Comments / Instructions

IV or Injections (IM, SQ)

Drug Name and Strength	Dose	Route	Frequency	Comments / Instructions

Nutrition/Hydration (TPN, tube feeds, free water, IV hydration, nutritional supplements)

Name	Quantity	Route	Frequency	Comments / Instructions

Vitamins, Supplements, Over-the-Counter Medications

Name	Quantity	Route	Frequency	Comments / Instructions

I hereby verify that this form contains all of the medications, vitamins, and supplements that my child is currently taking.

Signature of Parent/Guardian: _____ **Date:** _____

I hereby verify that I have reviewed this complete list of medications, vitamins, and supplements, and confirm that the combination poses no threat to the health of the above listed camper.

Name of Licensed MD, LPN, or PA: _____

Signature of MD, LPN, or PA: _____ **Date:** _____

Camper Name: _____ DOB: _____



 **2005 MEDICATION AUTHORIZATION FORM** 

MUST BE COMPLETED & SIGNED BY PARENT/GUARDIAN

General Guidelines: All campers must have their medications dispensed by the CCFA Medical Staff.

Medication Distribution Form: All medications (prescription and non-prescription) that your child is currently taking, as well as those taken under special circumstances, must be listed on the Medication Distribution Form. Please include any special instructions for administering these medications to your child.

Storage: All medications (prescription and non-prescription) must be turned in to the CCFA Medical Staff at the time of check-in. The CCFA Medical Staff will store and administer all medications as directed by your physician and you.

Late Change Form: Because your child's medication schedule may change prior to camp, we will send you a Late Change Form a few weeks prior to camp. This form will allow you to provide any recently updated information. The CCFA Medical Staff will review this form with you at check-in.

If a discrepancy exists between what is written on these forms and what is detailed on the prescription labels of the medication supplied at check-in, your child may not be admitted to camp until that issue is resolved. Please ensure that all information is correct and up-to-date.

Over-the-Counter Medications: If your child has a basic ailment (i.e. headache, sunburn) that is diagnosed by a CCFA doctor, s/he may be treated with an over-the-counter medication that the camp has in stock, as prescribed by the doctor. Note: Advil, aspirin, and Motrin will only be distributed when absolutely necessary.

Medication Allergies: Please list those medications to which your child is allergic: _____

CONSENT FOR MEDICATION DISTRIBUTION

I/We the parent(s) or legal guardian(s) of the above named participant have read the guidelines and information listed above.

I/We and our child's doctor have indicated the correct medication information in the **Medical Application Package**, listing all medications, dosages, time schedule, and special instructions.

I/We do hereby give permission to the CCFA Medical Staff to give our child any necessary over-the-counter medications and the medication(s) listed on the **Medication Distribution Form**.

Name of Parent/Guardian: _____

Signature: _____ **Date:** _____

Camper Name: _____

DOB: _____



2005 GENERAL AUTHORIZATION FORM

Name of child who will be a camper at CCFA Camp Oasis: _____ (hereinafter referred to as the "Applicant")

Note: Please read the following information carefully. *Every item on this page must be understood before signing.* If there are any questions, please contact the Camp's Director.

Please initial each box below:

I certify that I am the parent or legal guardian of the above named Applicant.

I understand that Applicant will be participating in many physical activities at the Crohn's & Colitis Foundation of America's (CCFA) Camp Oasis and its host site location (hereinafter referred to as the "Camp"), and I give permission for the Applicant to engage in all activities except as I have noted below:

Applicant may engage in all activities at the Camp except (continued on a separate page, if needed):

I authorize the Camp medical staff to provide the Applicant with medical care, which is deemed necessary by the Camp medical staff.

I authorize the Camp medical staff to consent to any emergency medical care or treatment, including the dispensing of medicine, examinations, immunizations, x-rays, tests, dental care, anesthetics, medical or surgical diagnosis or treatments, and hospital care, to be rendered to the Applicant as deemed necessary by the Camp medical staff. I also give consent for any transportation deemed necessary or appropriate, at the discretion of the Camp, in connection with the medical treatment of the Applicant.

I assume financial responsibility for any and all medical and other expenses incurred for or on behalf of the Applicant while at the Camp or offsite.

I authorize Camp medical staff to contact any of the Applicant's physicians and mental health professionals listed on the Applicant's forms, to obtain any records necessary for treatment, referral, billing or insurance purposes.

I authorize Camp medical staff to release Applicant's medical records to Camp medical and non-medical staff and to third parties, for the purposes of Applicant's medical treatment, the non-medical care of Applicant, referral, billing, or insurance purposes, as deemed necessary by Camp medical staff.

I authorize Camp to provide transportation to the Applicant, as needed, while the Applicant heads to, attends, and leaves the Camp. I release the Camp from all claims, damages and liabilities that may result, directly or indirectly, from any injury that Applicant may suffer during such transportation.

Camper Name: _____

DOB: _____

I give permission to the Camp to use Applicant's name, photographs, other reproduction(s) and likenesses in connection with activities and publications of the Camp.

I agree to allow the Applicant's name, mailing address, telephone number, and email address to be included in the CCFA Camp Oasis Directory.

I agree to be responsible for monitoring the Applicant's contact with all Camp staff and campers once Camp has ended.

I agree to be responsible for the pick-up of the Applicant if the Camp Director decides to send him/her home due to any serious violation of the Camp rules. I agree that the Camp Director shall be the sole judge of what constitutes a serious violation.

I understand that, in order for Applicant to attend the Camp, I must give up any rights to hold the Camp liable for any injury or damage, which the Applicant may suffer while attending the Camp or participating in the Camp's activities.

I voluntarily release the Crohn's & Colitis Foundation of America, its local chapters, Camp, and each of their officers, agents, trustees, employees, and volunteers from any and all liability resulting from or arising out of the Applicant attending the Camp or participating in the Camp's activities.

I understand and agree that this Release will have the effect of releasing, discharging, waiving and forever relinquishing any and all actions or causes of action that I may have or have had, whether past, present or future, whether known, or unknown, and whether anticipated or unanticipated by me, arising out of the Applicant attending the Camp and/or participating in the activities offered by the Camp. ***This Release constitutes a complete release, discharge and waiver of any and all actions or cause of action against the Camp, its officers, agents, or employees.***

I understand and agree that this Release will be binding on me, my spouse, the Applicant, my heirs, my personal representatives, my assigns, my children and any guardian ad litem for said children. I understand and agree that by signing this Release, I am agreeing to indemnify and hold the Camp, its officers, agents and employees harmless from any and all liability or cost, including attorneys fees associated with or arising from the Applicant attending the Camp and/or participating in the activities offered by the Camp.

I have read the above information carefully, and I have fully understood each item prior to initialing it. I understand that if I have any questions regarding anything contained in this Release, I may call the CCFA Camp Director.

This Release has been executed as (today's date): _____

Print Name: _____

Signature: _____

Capacity (Parent, Guardian, etc.): _____