



Dear Parent:

Thank you for your interest in **CCFA Camp Oasis**, located in Meridian Texas.

The 2007 Camp Session will take place from August 23 – 26 (Thursday – Sunday).

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!**

There is NO FEE to attend camp.

Please note that before your child can be considered for CCFA Camp Oasis, all of the attached forms must be completed and signed by the designated individuals.

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

Julie Diffenderffer - Camp Director
12801 North Central Expressway, Suite 270
Dallas, TX 75243
972-386-0584 - phone
972-386-0509 - fax
jdiffenderffer@ccfa.org

Once the forms have been received at the camp office, the Camp Director and Medical Director will review them and let you know if camp will be able to accommodate your child.

The application deadline is Friday July 13, 2007

To help you with the application process, an Application Checklist accompanies the application forms. If you have any additional questions, please contact the camp office at the number 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



2007 APPLICATION CHECKLIST

Please help us provide your child the best possible camp experience by taking the time to thoroughly complete this application. The tips and checklist we've provided below should help with the process.

HELPFUL TIPS

- Camp policy requires that every camper have record of a **physical exam from the current calendar year (2007)**. Please schedule your child's doctor appointment well in advance to allow time for all of the required medical forms to be completed by the application deadline.
- Camp policy requires that your child's **immunizations be up-to-date**. If you are uncertain of your child's status, please check with his/her doctor, and arrange to have any necessary vaccines given. If your child has not been vaccinated due to personal or religious reasons, you will need to request an Immunization Release Form from the camp office, and include it as part of your child's application.
- Please **type or print neatly** to ensure a quick and accurate review.
- **Please be sure that all of the forms are complete and have been signed by the appropriate people**, then return them together to the camp office listed on the previous page.
- **Use the checklist below** to help with this process.

Required Forms: The following is a list of the forms required in all camper applications.

Required Forms	Page(s)	Completed By:	Signature?
<input type="checkbox"/> Camper Application	2-6	Parent/Guardian	No
<input type="checkbox"/> Parent Questionnaire	7-8	Parent/Guardian	No
<input type="checkbox"/> General Authorization Form	9-10	Parent/Guardian	Yes: P/G
<input type="checkbox"/> Current Medication Form	11-12	Parent/Guardian	Yes: P/G & MD
<input type="checkbox"/> Physician's Form	13	Gastroenterologist	Yes: MD

Attachments: The following is a list of attachments that are **required** as part of every application.

- Copy of Insurance Card (both sides)
- Copy of Pharmacy Card (only if applicable)
- Copy of Immunization Record (only if information is not contained within application)

Supplemental Forms: The following is a list of those forms that should be included if applicable.

Supplemental Forms	Page(s)	Completed By:	Signature?
<input type="checkbox"/> Behavioral Support Form	14	Therapist/Social Worker	Yes: T/SW
<input type="checkbox"/> Immunization Release Form	NA	Parent/Guardian	Yes: P/G



2007 CAMPER APPLICATION

Attach Camper Photo Here

FOR OFFICE USE ONLY

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

FINAL: ACC / DEC / WTL

TO BE COMPLETED BY PARENT OR GUARDIAN (Please print legibly.)

Camper's Full Name: _____ Nickname: _____
 Age on 7/1/07: _____ Birth date: _____ Male Female School Grade in 06-07: _____
 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 (circle one): Youth S M L XL Adult S M L XL XXL

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 CCFA 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: You must also include a **2-sided copy of the insurance card** (and pharmacy card, if applicable).

Insurance company: _____

Address: _____

Contact number: _____ Policy/Group number: _____

Name of insured: _____ Relationship to camper: _____

CCS number (if applicable): _____ Medicaid/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 Medical Professionals' Contact Information

Additional doctor's name: _____ Phone: _____

Dentist's name: _____ Phone: _____

Social worker's name: _____ Phone: _____

Therapist's name: _____ Phone: _____

Camper Name: _____ DOB: _____

Medical History

IBD Diagnosis: _____ **Date of diagnosis:** _____

Other Medical Conditions: Please check any other medical conditions that your child has.

- rashes vision loss hearing loss earaches hearing aid(s) fainting episodes
- palpitations hypertension immunodeficiency urinary tract infec diabetes bleeding disorder
- kidney infection arthritis sinusitis strep throat hay fever headaches
- constipation stomach aches PE tubes incontinence anxiety depression
- ADD/ADHD nightmares sleepwalking bed wetting night terrors
- asthma *Please specify severity:* Mild Moderate Severe
- seizure(s) *Date of last seizure:* _____ Others Conditions: _____

If female, has she begun her menstrual cycle? Yes No Typical treatment for cramps: _____

Comments on IBD and other checked conditions:

Anatomy/Device: Please indicate whether your child has any of the anatomy/devices listed below.

	Circle One	If Yes: Describe Care
Ostomy	Yes / No	
G-Tube or NG Feeding Tube	Yes / No	
J-Pouch	Yes / No	
Central Line/Portocath	Yes / No	
Any Other Anatomy/Devices (fistula, fissures)	Yes / No	

Medical Care: Please indicate the nature of your child's medical care in the past 12 months.

	Date of Most Recent	Reason for Most Recent	Number in Past 12 Mos.
Doctor Visit			
ER Visit			
Hospitalization			
Surgery			

Behavioral Support

Has your child seen a **therapist or social worker** in the past 12 months? Yes No

Is your child **currently taking any mood altering medication**? Yes No

If YES to either of the above, please submit the **Behavioral Support Form** as part of the application.

Camper Name: _____ DOB: _____

Immunization Record

NOTE: Please **complete the box below or attach a copy** of the child's immunization record.

DTaP/DT/Tdap: _____	MMR: _____
Date of Last Tetanus Booster: _____	Hepatitis B: _____
Polio (IPV/OPV): _____	Hepatitis A: _____
Varivax: _____	Pneumoccal (PCV, Prevnar, Pneumovax) _____
Meningococcal: _____	HIB/H.flu Vaccine: _____
TB Skin Test (optional): _____ Results: Positive / Negative	If positive, explain treatment: _____

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

Food/Nutrition

Please list any food restrictions or special dietary requirements.

Allergies

Please list all of your child's allergies, and the typical course of treatment.

	Allergy	Reaction	Typical Course of Treatment
Medication <i>Ex: penicillin</i>			
Food <i>Ex: peanuts, strawberries</i>			
Other <i>Ex: insects, animals, pollen</i>			

Family History

Please check if anyone in your immediate family has:

- diabetes cancer high blood pressure heart disease
 thyroid disease seizures kidney disease HIV (optional)

tuberculosis If so, is this person on current treatment for TB? Yes 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. **NOTE: Not all of the listed activities are offered at every CCFA Camp Oasis site.**

Please indicate if your child is able to participate in each activity, and comment on any limitations.

Program Area	Participation Okay?	Comments
Arts & Crafts	Yes / No	
Baking	Yes / No	
Boating and fishing	Yes / No	
Creative Arts: Writing & Photo	Yes / No	
Discovery: Science & Nature	Yes / No	
Gardening	Yes / No	
Horseback riding	Yes / No	
Outdoor camping	Yes / No	
Performing Arts	Yes / No	
Ropes course	Yes / No	
Sports & Recreation	Yes / No	
Swimming	Yes / No	
Woodworking	Yes / No	

What is your child's swimming level? can't swim beginner intermediate advanced
 May your child participate in supervised swim activities? Yes No

Camper Mobility

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

Please place a check next to any supportive devices that your child uses/will need at camp.

wheelchair crutches splints
 brace(s) artificial limb(s) other: _____

Comments:

Daily Living: Please specify the level of care your child requires.

	Independent	Close Supervision	Moderate Assistance	Total Care
Daily care (i.e. dressing, brushing teeth)	<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"/>

Comments on any of the above:

Camper Name: _____ DOB: _____



2007 PARENT QUESTIONNAIRE

The following questions should be completed by one or both parents/guardians, after consulting with the camper. Thank you in advance for your honest feedback, which will ensure that we are able to provide your child with the most positive camp experience possible.

1. Has your child ever been to camp before? yes no
- Day Camp: _____
- Sleep-away Camp: _____

Comments:

2. Has your child ever been away from home for more than 5 days? yes no

3. How does your child feel about going to camp?
- nervous excited fearful hopeful other: _____

4. Please check all of the characteristics that describe your child:
- | | |
|--|--|
| <input type="checkbox"/> gets along well with others | <input type="checkbox"/> makes friends easily |
| <input type="checkbox"/> shy | <input type="checkbox"/> easily frustrated/angered |
| <input type="checkbox"/> a leader | <input type="checkbox"/> especially active |

Comments:

5. What are your child's interests, hobbies, and special talents?

6. In what situations/environments does your child excel?

7. In what situations/environments does your child feel least comfortable?

8. What challenges might your child's camp counselor encounter with your child? What is the best way to resolve them?

Camper Name: _____ DOB: _____

9. Bedtime can be a difficult time for some children. Please check any of your child's bedtime/sleep habits:

- | | |
|---|---|
| <input type="checkbox"/> night terrors | <input type="checkbox"/> fear of the dark |
| <input type="checkbox"/> difficulty going to sleep | <input type="checkbox"/> snoring |
| <input type="checkbox"/> difficult waking up in the morning | <input type="checkbox"/> bedwetting |
| <input type="checkbox"/> nightmares | <input type="checkbox"/> other _____ |

Comments:

10. How involved is your child in managing his/her IBD? very somewhat not at all

11. Please check which, if any, IBD-related issues are hardest for your child to manage/cope with?

- Peers/Relationships Body Image Adherence Other: _____

Comments:

12. At times, all children can feel frustrated or angry. When your child is angry, how does s/he handle his/her anger? Any suggestions for helping your child in such situations?

13. Does your child have any unusual behaviors or fears? yes no

If yes, please explain.

14. Please check if your child has been diagnosed with:

- ADD/ADHC Anxiety Depression Other Behavioral/Emotional: _____

If yes, has medication been prescribed? yes no

Is your child currently taking these medications? yes no

Will your child be taking these medications at camp? yes no

15. Have there been any recent changes in your child's life, family or living arrangements about which we should be aware?

- Death Divorce Moving Custody Issues Change of Schools

If checked, please explain.

16. If you will not be at home/work while your child is at camp, where will you be and what number(s) should we use to contact you?

17. Please offer any additional information that might help us better serve your child.

Camper Name: _____ DOB: _____



2007 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 Director.

Initial Each Box:

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

I certify that I have provided accurate information in all parts of the application.

I understand that Applicant will be participating in many physical activities at CCFA Camp Oasis and its host site location (hereinafter referred to as the "Camp"), and I give permission for Applicant to engage in all activities except as I have noted below (continue on a separate page, if needed):

I authorize Camp to release Applicant's 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 staff.

I authorize Camp medical staff to provide Applicant with medical care and medication according to the instructions provided in the Applicant's forms, or, for issues not detailed in the forms, as deemed necessary by Camp medical staff.

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

I authorize 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 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 Applicant while at Camp or offsite.

Camper Name: _____ DOB: _____

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

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

I agree to allow Applicant's name, mailing address, telephone number, and email address to be included in the CCFA Camp Oasis Directory, which is distributed to all campers after camp has ended.

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

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

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

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): _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

*NOTE: If you do **NOT** want your child to be included in the CCFA Camp Oasis Directory, please sign here instead:*

Parent/Guardian Signature: _____



DIRECTIONS FOR CURRENT MEDICATION FORM

MUST BE COMPLETED & SIGNED BY PARENT & LICENSED GASTROENTEROLOGIST

On the next page you will find a **Current Medication Form**, designed to reflect all of the medication that your child is currently taking. It will be used to guide your child's medication regimen at camp.

A few weeks prior to camp, **you will have the opportunity to update this list** to reflect any changes.

Included below is a SAMPLE of a completed section of the form. Please use it as a guide.

Oral Meds, Vitamins, Supplements	Dose/Frequency		D1	D2	D3	D4	D5	D6	D7
Drug Name: DRUG XYZ Strength/Concentration: 10 mg	Break: 1 pill								
	Lunch: NA			DO NOT COMPLETE					
	Dinner: 2 pills			DO NOT COMPLETE					
	Bed: NA								
IV, Injections, Feeding Tubes, etc.	Dose	Time/Freq	D1	D2	D3	D4	D5	D6	D7
Drug Name: DRUG ABC Strength/Concentration: 10 mg/ml Route/Instructions: injection; alternate left & right arm; camper can do herself	0.5 ml	3PM/daily		DO NOT COMPLETE					

Completion Instructions:

1. **List ALL of your child's current medications**, vitamins, supplements, injections, etc..
2. **Complete only the left side** of the form: *Drug Name, Strength, Dose, Frequency*. (The camp staff will complete the right side when the medication is administered.)
3. **Print clearly** or type the information, so it is legible to the reviewer.
4. **Specify the prescribed strength** of each medication in milligrams (mg); for liquids, indicate the concentration of the mixture in mg/ml.
5. **Specify the exact dosage** required at each of the corresponding distribution times. (NOTE: To ensure a well-functioning camp schedule, medication will only be distributed at *breakfast, lunch, dinner, and bedtime* unless special arrangements are made with the Camp Director and Medical Team.)
6. **Use another page**, if there is not enough room for all of your child's medications on one.
7. **Sign at the bottom, and have your child's gastroenterologist do the same**, after reviewing the form.

Camper Name: _____ DOB: _____ TODAY'S DATE: _____

2007 CCFA Camp Oasis Current Medication Form

Diagnosis: _____ **Allergies:** _____

Is your child receiving ongoing Remicade treatments? Yes / No

If yes, how often?: _____ Last Treatment Date: _____ Next Treatment Date: _____

		FOR CAMP STAFF USE ONLY							
		↓ Dates of Camp: ↓							
Oral Meds, Vitamins, Supplements	Dose/Frequency	D1	D2	D3	D4	D5	D6	D7	
Drug Name:	Break:								
	Lunch:								
	Dinner:								
	Bed:								
Strength/Concentration:	Break:								
	Lunch:								
	Dinner:								
	Bed:								
Drug Name:	Break:								
	Lunch:								
	Dinner:								
	Bed:								
Strength/Concentration:	Break:								
	Lunch:								
	Dinner:								
	Bed:								
Drug Name:	Break:								
	Lunch:								
	Dinner:								
	Bed:								
Strength/Concentration:	Break:								
	Lunch:								
	Dinner:								
	Bed:								
Drug Name:	Break:								
	Lunch:								
	Dinner:								
	Bed:								
Strength/Concentration:	Break:								
	Lunch:								
	Dinner:								
	Bed:								
IV, Injections, Feeding Tubes, etc.	Dose	Time/Freq	D1	D2	D3	D4	D5	D6	D7
Drug Name:									
Strength/Concentration:									
Route/Instructions:									
PRN (As Needed)	Purpose	Dose	D1	D2	D3	D4	D5	D6	D7
Drug Name:									
Drug Name:									

FOR PARENTS: I hereby verify that this Current Medication Form contains all of the medications, vitamins, and supplements that my child currently takes.

Signature: _____ Date: _____

FOR MD: I hereby verify that I have reviewed the completed Current Medication Form, and approve the list for distribution at CCFA Camp Oasis.

Signature: _____ Date: _____

Camper Name: _____

DOB: _____



2007 PHYSICIAN FORM

MUST BE COMPLETED & SIGNED BY LICENSED GASTROENTEROLOGIST

IBD Diagnosis: _____ Extent/Location: _____

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

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

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

Other Medical Conditions (i.e. asthma): _____

Significant Events/Surgeries (What/When): _____

Is the child's cognitive development appropriate for his/her age? Yes No

If no, at what approximate age does the child function?: _____

Date of Most Recent Exam: _____. Please include the exam findings below.

Weight: _____ Height: _____

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

Growth: Acute Weight Loss Chronic Growth Failure

Stools: ___/Day; ___/Week Form Semi Loose Blood Mucus Nocturnal

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

I understand that the above listed 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 Medical Team consisting of physician(s) *(including a gastroenterologist)*, nurses, and a mental health professional will be on-site and on-call 24-hours a day to provide basic care during camp.

Based on this information and my collective work with the above listed camper, I believe that CCFA should:

- DECLINE** this camper's application. Please explain: _____
- ACCEPT** this camper's application. **Limitations/restrictions:** _____

MD Name: _____ Phone Number(s): _____

Signature: _____ Date: _____

Camper Name: _____

DOB: _____



2007 BEHAVIORAL SUPPORT FORM

THIS FORM IS REQUIRED if: **(1)** your child has seen a mental health professional (i.e. therapist, social worker) in the past 12 months, AND/OR **(2)** he /she is currently taking a mood altering medication.

THIS FORM MUST BE COMPLETED BY: **(1)** your child’s mental health professional, if applicable, OR **(2)** the medical professional that prescribed the mood altering medication.

Name of Person Completing Form: _____

Profession: _____

Relationship to Camper: _____

How long have you been working with the camper? _____

Date of Most Recent Visit: _____

Number of Visits in Past 12 Months: _____

Diagnosis/Reason for Treatment: _____

Behavioral manifestations that may appear at camp & suggested ways to manage:

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

If yes, please explain:

Can this child function at camp with only basic care from the mental health provider? No Yes

If no, please explain:

Essential Medications: _____

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 Medical Team consisting of physicians (*including a gastroenterologist*), nurses, and a mental health professional will be on-site and on-call 24-hours a day to provide basic care during camp.

Based on this information and my collective work with the above listed camper, I believe that CCFA should:

DECLINE this camper’s application. Please explain: _____

ACCEPT this camper’s application. **Limitations/restrictions:** _____

MD/Therapist/SW Name: _____	Title: _____
Signature: _____	Date: _____ Emergency Phone: _____