2017
Camp No Worries
Camper Application(Patient)

GENERAL INFORMATION:

Camper's Full Name: (Last): ______________________ (First): ______________________

Nickname/Name Child Prefers: ______________________

Address: ______________________ City/Town: ______________________

State: ____________ Zip Code: ______________

Phone Number: ______________________

What is your preferred method of communication: Please circle – **Phone/Text/Email**

DOB: ____________ Age: ________ Gender: M ☐ F ☐

Cancer Diagnosis: ______________________ Date of Diagnosis: ____________

Relapse Date (If applicable): ______________

***Child Must know his/her Diagnosis**

Will your child be receiving treatment for cancer throughout the week? : Y ☐ N ☐

If yes, what type of medication? (oral chemo, injections, etc.): ______________________

Will your child be receiving other medication while at camp? : Y ☐ N ☐

Who has primary/legal custody of camper? (mother/father/guardian/other): ______________

Parent(s)/Guardian(s) Name: ______________________

Relationship to camper: ______________________

Who does camper primarily live with: ______________________

Address (if different from camper's above): ______________________

______________________ City/Town: ______________________

State: ______________ Zip Code: ______________

Phone Number: ______________________

Parent/Guardian Email Address: ______________________ Cell #: ______________

EMERGENCY CONTACTS (If Parent or Guardian cannot be reached)

1. Name: ______________________ Phone #: ______________

   Relationship to Patient: ______________ Work #: ______________

   Cell #: ______________

2. Name: ______________________ Phone #: ______________

   Relationship to Patient: ______________ Work #: ______________

   Cell #: ______________

PHYSICIAN INFORMATION:

Pediatrician: ______________________ Oncologist: ______________________

Institution: ______________________ Institution/Treatment Ctr: ______________

Address: ______________________ Address: ______________________

______________________ ______________________

Phone #: ______________________ Social Worker: ______________________

Emergency #: ______________________ Phone # ____________ Fax #: ____________

Emergency #: ______________________

TEE SHIRT SIZE? ☐ Youth Medium ☐ Adult Small ☐ Adult Medium
(Please Check One) ☐ Adult Large ☐ Adult X-Large ☐ Adult XX-Large

MEDICAL INFORMATION

ALLERGIES/FOOD RESTRICTIONS:
Does your child have any diet restrictions/special dietary needs? Y: ☐ N: ☐
If yes, please explain: ____
____

Allergies (foods/meds/environment/etc.) *Please list all allergies & describe the reaction & management of reaction)*

Medication Allergies: Y: ☐ N: ☐ *if yes, please explain*
1.______________________ Reaction/ Treatment______________
2. ______________________ Reaction/Treatment______________
3. ______________________ Reaction/Treatment______________
4. ______________________ Reaction/Treatment______________

Food Allergies: Y: ☐ N: ☐ *if yes, please explain*
1.______________________ Reaction/ Treatment______________
2. ______________________ Reaction/Treatment______________
3, ______________________ Reaction/Treatment______________
4. ______________________ Reaction/Treatment______________

Other Allergies: Y: ☐ N: ☐ *if yes, please explain*
1.______________________ Reaction/ Treatment______________
2. ______________________ Reaction/Treatment______________
3, ______________________ Reaction/Treatment______________
4. ______________________ Reaction/Treatment______________

MEDICAL INFORMATION:

Does your child have any other medical; conditions, please check yes or no, if yes, please describe:

ADD/ADHD/Autism Spectrum Disorder	Y: ☐	N: ☐
Asthma	Y: ☐	N: ☐
Headaches	Y: ☐	N: ☐
Seizures	Y: ☐	N: ☐
History of Constipation/Diarrhea	Y: ☐	N: ☐
Has your daughter begun her menses	Y: ☐	N: ☐
Does your child wear eyeglasses	Y: ☐	N: ☐
Does your child wear contacts	Y: ☐	N: ☐
Does your child wear protective eyewear	Y: ☐	N: ☐
Is your child under care of a mental health provider? (i.e. psychologist, therapist, counselor)	Y: ☐	N: ☐

If yes to any of the above, please explain: ______________________________
____
____

Does your child use a mobility device Y: ☐ N: ☐
If yes, please explain: ____

Has your child had the chicken pox or chicken pox vaccination: Y: ☐ N: ☐
If yes, please list disease/vaccination & date: ______________________________

Please note: You must alert us if your child has been exposed to any communicable disease (chicken pox, measles, mumps, shingles) 1-3 weeks before first day of camp

CAMPER NEEDS:

Please inform us of any needs that your child has so that we can make his/her camping experiences as enjoyable and safe as possible. Please check yes or no.

Has your child been classified as having a learning disability:	Y: ☐	N: ☐
Has your child ever been classified with having behavior problems:	Y: ☐	N: ☐
Does your child have a specific nighttime routine:	Y: ☐	N: ☐
Does your child sleep walk:	Y: ☐	N: ☐
Does your child suffer from nightmares:	Y: ☐	N: ☐
Does your child awaken in the middle of the night:	Y: ☐	N: ☐
Does your child wet the bed:	Y: ☐	N: ☐

If you answered yes to any of the above, please describe:

Does your child need encouragement: Y: ☐ N: ☐
If so, in what way?

Has there been significant life changes for your child within the past year? (Ex. new baby, new school, new home, divorce, etc.)

Please describe in detail any physical disability and/or physical limitations that may affect participation in any camp activity:

Level of Assistance For Your Child Please Check Appropriate Column(s)				
	Independent	Some Help	Almost Total Help	Complete Assistance Required
Daily Care (teeth, hair, dress)				
Medication Taking				
Meals				
Bathing/Showering				
Toileting/Bathroom				
Swimming				
Extended Walking				

How does your child get along with other children? (taking turns, disputes, group activities, sharing, etc.):

Camp No Worries is 100% committed to the health and safety of your child(ren) during the week of camp. If there is any additional information about your child that would assist us in understanding him/her, please provide us with that information. (Example: fears, strengths, personality traits, routines.)

If possible my child would like to be bunked with…
1.____
2.____
We will do our best to accommodate requests, but requests are not a guarantee of placement, brothers and sisters and siblings in different age groups will not be bunked together as cabin assignments are based on gender and age

Has your child ever attended overnight camp before: Y: ☐ N: ☐
If yes, please list the year and name of camp:

1. __________________________ 2. _________________________ 3.______________________________

CONSENT FOR MEDICAL TREATMENT
The undersigned parent/legal guardian hereby grants permission to the medical staff or consulting physicians at Camp No Worries to administer medication and provide medical care for my child, including any medical emergency care required. I also give consent for any emergency transportation as deemed necessary.

X____ ______________________________
Signature of Parent/Legal Guardian Date

INSURANCE INFORMATION
Please attach a photocopy of your insurance card and prescription card, to be used for special tests, x-rays, and prescriptions if necessary.
Any specific billing instructions:

CONSENT AGREEMENT, AUTHORIZATION AND RELEASE

This consent agreement, authorization and release must be read and signed by a parent/legal guardian in order for your child to be eligible to attend camp.

As parent/guardian of ____, I hereby waive and release Camp No Worries, the YMCA of Burlington and Camden Counties, and any co-sponsoring organizations from liability for injuries, damages, or loss of personal property.
X____ ______________________________
Signature of Parent/Legal Guardian Date