Camp Gibbous (ages 15-18)

Sickle Cell Disease Foundation of California
3602 Inland Empire Blvd., Suite B140, Ontario, CA 91764
Phone (909) 743-5226 • Fax (909) 743-5227 • Email: portiar@scdfc.org • Website: www.scdfc.org

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Dear Parent or Guardian:

Camp Gibbous is pleased to invite your teen to attend camp this summer. **Teens with sickle cell disease between the ages of 15-18 are eligible to attend.** If your child is between the ages of 7-14, please apply for Camp Crescent Moon. The camp dates are August 24-26, 2018.

Inside your packet, you will find the following:

1. **Camp Gibbous Application** – you can submit the application before the physical form
2. **Health History/Physical** - *must be completed by child's **DOCTOR***
3. **Teacher Questionnaire**

Application **DUE DATE: Thursday, July 24th.**

Please complete the enclosed application and return to us by July 24th.

Priority will be given to ACTIVE* members of the SC Crew. There are 25 spaces available to Inactive* & Non SC Crew members and are on a first come first served basis (please submit application as soon as possible). We wish we could take every teen who applies but we do not have room for everyone to attend.

The registration fee for Camp Gibbous is $20 for Inactive & Non SC Crew Members.
Camp Gibbous is FREE of charge to ACTIVE* SC Crew Members.

Please read all of the information very carefully. **If you have any questions or need help with the application, please call our office as soon as possible.**

Please call your child's doctor as soon as possible to make an appointment for a physical exam.
The medical information we need must be current. We will request an update of your teen's health status from his/her doctor before camp.

Again, if you need help with this application or if you have any questions, please call us at (909) 743-5226 or toll free at (877) 288-2873. **When you mail or fax the application, we suggest that you call our office to make sure we received it.** *We look forward to seeing you in August!*

Sincerely

Deborah Green

Program Administrator/Director of Health Education
Assistant Camp Director

**Active = SC Crew Members who have attended at least two meet ups in 2018.*

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Teen's Name:____ Nickname: ________________
First Name M.I. Last Name Suffix (Jr., Sr., II, III, etc)

Date of Birth: ______/______/______ Age: _______ ❑ Female ❑ Male Current Grade in school: _______

Address: ____

City: ____________________________ State: ______________ Zip Code: ___________

Home Phone: ( ) ____________________ Does teen speak English? ❑ Yes ❑ No

Teen's primary language: ❑ English ❑ Spanish ❑ Other: *(specify)* ________________________

Parent / Legal Guardian

Full Name: ________________________________ Email: ______________________

Address: ____________________________ City: ______________ St: _____ Zip: ______

Home Phone: ( ) ____________________ Cell Phone: ( ) ____________________

Employer: ______________________________ Work Phone: ( ) __________________

Relationship to teen: ❑ Mother ❑ Father ❑ Other: *(specify)* ____________________________

Parent / Legal Guardian

Full Name: ________________________________ Email: ______________________

Address: ____________________________ City: ______________ St: _____ Zip: ______

Home Phone: ( ) ____________________ Cell Phone: ( ) ____________________

Employer: ______________________________ Work Phone: ( ) __________________

Relationship to teen: ❑ Mother ❑ Father ❑ Other: *(specify)* ____________________________

Who does teen live with? *(please check all that apply)*
❑ Both Parents ❑ Mother ❑ Father ❑ Stepfather ❑ Stepmother ❑ Brother(s) # _____ ❑ Sisters(s) # ____
❑ Grandmother ❑ Grandfather ❑ Other *(specify)* ___________________________________

If parents are divorced or separated, who has legal custody? ❑ Both Parents ❑ Mother ❑ Father ❑ Other: ______

Emergency Contact Information

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

Full Name: ________________________ Full Name: __________________________

Address: ___________________________ Address: ____________________________

City/St/Zip: ________________________ City/St/Zip: __________________________

Phone: ( ) _________ ( ) _________ Phone: ( ) _________ ( ) _________

Relationship to camper: _________________ Relationship to camper: ____________________

Medical Insurance Information *(Please include a copy of medical 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)*: __________________

TEEN Camper Profile

TEEN CAMPER INFORMATION

Teen's Diagnosis (check one)

❑ **SS** (Sickle Cell Anemia) ❑ **SC** (Sickle Cell C Disease)
❑ **S-Thal** (Sickle Beta Thalassemia) ❑ **Other/Unsure (specify):** ___________________________

Teen's T-shirt Size (check one)

❑ Youth Medium (10-12) ❑ Adult Small ❑ Adult Large ❑ Adult 2X ❑ Adult 4X
❑ Youth Large (12-14) ❑ Adult Medium ❑ Adult X-Large ❑ Adult 3X

1. Is your teen **ALLERGIC** to any **FOODS OR MEDICINES**? ❑ Yes ❑ No If yes, specify:________________________
____
2. Please list any food restrictions: ❑ Vegetarian ❑ Lactose Intolerant ____
____
3. Are there any disabilities that would prevent your teen from participating in camp activities? Please list them below:
____

CAMPING EXPERIENCE

1. Has your teen attended CAMP CRESCENT MOON before? ❑ Yes ❑ No Most recent year: ______________
2. How did you learn about CAMP GIBBOUS? ❑ From the SCDFC ❑ Doctor/Nurse ❑ Other _____________
3. Is your teen a registered, active participant of the SC Crew Teen Transition Program? ❑ Yes ❑ No

PERSONALITY TRAITS

The following questions will assist us in providing the best camp experience possible for your teen.

1. What kinds of challenges may your teen's camp counselor most likely encounter from your teen? What is the best way to resolve them? ____
____
2. When upset, how does your teen show aggression towards others? ____
____
3. Does your teen have any unusual behaviors or fears? ❑ Yes ❑ No If yes, please describe _____________________
____
4. Has your teen been diagnosed with ADD or ADHD? ❑ Yes ❑ No If yes, is he/she taking any medications to manage it? ❑ Yes ❑ No Please list the medications: ____
5. Is your teen overly sensitive? ❑ Yes ❑ No If yes, in what way? ____
6. Do you know if your teen is sexually active? ❑ Yes ❑ No ❑ Maybe ❑ I don't know
7. Do you know if your teen uses drugs (illegal, street, illicit) or alcohol? ❑ Yes ❑ No ❑ Maybe ❑ I don't know
8. Do you know if your teen uses tobacco, marijuana or vaping products? ❑ Yes ❑ No ❑ Maybe ❑ I don't know
9. Have there been any recent changes in your family or living arrangements that we should be aware of (death, moving, divorce, etc.)? ____
____
____
10. How do you think your teen can benefit by attending Camp Gibbous? ____
____
____

11. Do you have transportation to drop off/pick up your teen at the campsite in Orange county? ❑ Yes ❑ No ❑ Unsure

12. Will your child be in school on the Friday of Camp Gibbous (August 24th) ❑ Yes ❑ No ❑ Unsure
    If yes, what time does your child get out of school? ____________ am/pm

MEDICATIONS - My teen is currently taking the following medications:

	Medication	Dose/Amount	Frequency/How often
1)			
2)			
3)			
4)			

Please attach separate sheet if needed.

<u>**CONFIDENTIAL**</u> CAMPERSHIP INFORMATION

To Parents and Guardians:

Camp Gibbous is made possible by donations and grants from public and private donors. Without these generous gifts, the cost you would pay for each teen would be $500.

Camper's Race/Ethnicity:
❐ African American/Black
❐ Hispanic/Latino(a)
❐ Filipino(a)
❐ Pacific Islander
❐ Asian
❐ White
❐ Other *(please specify)*______________________

What is the **TOTAL** number of people who live in the home? __________

Who are the primary income providers?____

ANNUAL FAMILY INCOME

Please check the amount closest to your family income (per year)

❐ $6,500 ❐ $8,500 ❐ $9,800 ❐ $13,200 ❐ $16,600 ❐ $17,705 ❐$23,736
❐ $29,767 ❐ $35,798 ❐ $41,829 ❐ $47,860 ❐ $53,891 ❐ $59,922 ❐ Over

COUNTY/GOVERNMENTAL ASSISTANCE

If you or your child(ren) receive assistance, please indicate your case number(s) below:

❐ TANF/AFDC: ____

❐ Social Security: ______________________________________ ❐ teen ❐ parent

❐ Food Stamps/Cal Fresh/SNAP

Camp Gibbous

Sickle Cell Disease Foundation of California

RELEASE FOR EMERGENCY TREAMENT AND LIMITATION OF LIABILITY

❑ I am the **PARENT, GUARDIAN OR CAREGIVER** authorized to give consent for medical and dental care of ____, a camper who is under 19 years of age, who will travel to and attend Camp Gibbous during the dates of August 24 – 26, 2018 *(if a caregiver, I am a relative of camper and can authorize medical and dental care for camper under California Family Code §6550).*

OR

❑ I ______________________________________ am a **VOLUNTEER** over 18 years of age who will travel to and attend Camp Gibbous during the dates of August 24 – 26, 2018.

Pursuant to California Family Code §6910, I hereby authorize the Director, Doctor or Nurse of Camp Gibbous to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor under the general or special supervision and upon the advice of a physician and surgeon licensed by the Medical Board of California, or consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered to the minor by a dentist licensed by The Dental Board of California. This authorization shall be effective whether such diagnosis, treatment or care is rendered at the office of said physician or dentist, at a hospital, at Camp Gibbous, or elsewhere, and shall remain effective while I am or my said teen/ward is in route to or from or involved or participating in any program or activity of Camp Gibbous, unless earlier revoked by me in writing and delivered to the Director.

I hereby acknowledge that for proper functioning of Camp Gibbous, a unique summer camp exclusively for teens with sickle cell disease, it is necessary that the doctor / nursing / therapist staff at the camp be able to discuss the Camper/Volunteer's health issues with the non-medical counseling and other staff so that the staff is able to assist with providing a camp experience which is sensitive to and consistent with the Camper/Volunteer's health issues, limitations, and requirements. While the camp staff does not provide health care, they need to understand the health conditions to assure that activities are tailored to the needs, abilities and limitations of those attending the camp.

I further acknowledge that discussions between the doctors and nurses and the non-medical staff may be filmed for promoting interest in Camp Gibbous by the general public and by potential donors. The undersigned acknowledges that such discussions may include medical record information pertaining to the Camper/Volunteer. I further understand that such film may be submitted to news organizations and other commercial broadcast facilities for human interest coverage of the Camp, its campers and staff or used at Camp Gibbous fundraising functions or to supplement a Camp Gibbous speech to hospitals, businesses, groups or organizations.

In full consideration of the foregoing, the undersigned hereby authorizes the medical staff of Camp Gibbous, including without limitation, its doctors, nurses, therapists, as applicable, to disclose the undersigned's full medical record information to the non-medical staff of Camp Gibbous for the purposes stated above and the undersigned further authorizes that such medical information discussions between the medical staff and non-medical staff at Camp Gibbous may be filmed for the purposes stated above.

On my own behalf and on behalf of my teen/ward, I hereby expressly release, discharge and hold harmless Camp Gibbous, the Sickle Cell Disease Foundation of California and the Irvine Regional Outdoor Education Center and their respective agents, employees, officers, directors and representatives, from any liability or responsibility relating to or arising from any damage, loss or injury sustained by Camper/Volunteer while traveling to or from Camp Gibbous, while attending Camp Gibbous, while participating in any activities at Camp Gibbous or any trips or activities sponsored by the Sickle Cell Disease Foundation of California, or while staying in any accommodations provided or arranged by Camp Gibbous or by the Sickle Cell Disease Foundation of California, other than such liability or responsibility which may arise as a result of their gross negligence or willful misconduct. Without limiting the generality of the foregoing, this release includes within its scope any loss, damage or injury sustained as a result of any ordinary negligence, whether active or passive on the part of Camp Gibbous, the Sickle Cell Disease Foundation of California, or any of their officers, agents, employees or representatives.

The foregoing release is to be construed in accordance with the laws of the State of California. It is intended to release claims which are known and which are as yet unknown. Accordingly, I hereby waive on my own behalf and on behalf of Camper/Volunteer, the provisions of the California Civil Code Section 1542 which provides:

“A general release does not extend to claims which the creditor does not know or suspect to exist in his or her favor at the time of executing the release, which if known by him or her must have materially affected his or her settlement with the debtor.”

I have read and understood the Camp Gibbous health history/physical form, and the information I have given is true and correct.

Dated: _____________________, 2018

X ____
Signature

____
Print Name

PUBLICITY RELEASE

For good and valuable consideration from the Sickle Cell Disease Foundation of California and Camp Gibbous, the adequacy and receipt of which I hereby acknowledge, I hereby expressly grant to the Sickle Cell Disease Foundation of California and Camp Gibbous, or any third party either of them may authorize, and to their employees, agents and assigns, the right to photograph me (or my teen/ward) and/or make recordings of my/his/her voice, and the right to use pictures, recordings and other reproductions of my/his/her physical likeness or voice (as the same may appear in any still-camera photographs, videotape, and/or motion picture film) for any advertising, promotion, and/or fundraising, without any further compensation. All such photographs, videotapes, motion picture films, and recordings, and all negatives or masters thereof, shall be the sole and exclusive property of the Sickle Cell Disease Foundation of California and Camp Gibbous.

I hereby certify and represent that I have read the foregoing and fully understand the meaning and effect thereof and, intending to be legally bound, I have hereunto set my hand this _____________ day of _________________ 2018.

X ____
Signature

____
Print Name

Camp Gibbous (ages 15-18)

MAIL FORMS TO: Sickle Cell Disease Foundation of California
3602 Inland Empire Blvd., Suite B140 Ontario, CA 91764
Phone (909) 743-5226 • Fax (909) 743-5227 • email: deborahg@scdfc.org

HEALTH HISTORY/PHYSICAL TO BE FILLED OUT BY A PHYSICIAN ONLY

To Practitioners filling out the sickle cell teen camp pre-participation physicals,

Attached is a health history and physical application for Camp Gibbous, a weekend camp for teens (age 15-18) with sickle cell disease ***(sickle cell trait does not qualify)***.

Camp Gibbous is scheduled for August 24-26, 2018, however the application is **due to the SCDFC no later than Tuesday, July 24th.**

Please complete the health history form in its entirety, do not leave any areas incomplete. It will delay the teen's application and acceptance in the program.

We ask that you provide the most recent lab data **(within six (6) months)** to ensure our ability to provide the best medical care possible for your patient while he or she attends camp.

Please ensure that ALL critical information is included, such as type of sickle cell disease, hemoglobin/hematocrit and/or height/weight. While caring for your patients at the camp, such information is necessary for calculating drug doses for example or for establishing differential diagnosis. As you can imagine, this kind of information might be crucial for a particular acute situation in the camp setting, which is typically in a rural location.

Thus, we implore you to help us take better care of your patients by providing us with the information requested. If your nurse or other personnel is filling out the form, please review the form carefully before signing and sending it in.

Please keep in mind that we will contact you by mail prior to camp to provide us with any medical updates or changes in the status of the child.

If we can be of any assistance to you, please do not hesitate to call the SCDFC at (909) 743-5226.

Sincerely,

Cage S. Johnson, MD
Medical Director, Camp Crescent Moon

Camp Gibbous (ages 15-18)

Health History and Physical 20__

Sickle Cell Disease Foundation of California
3602 Inland Empire Blvd., Suite B140
Ontario, CA 91764
Phone: (909) 743-5226 Fax: (909) 743-5227
Toll free: (877) 288-CURE
Email: deborahg@scdfc.org
Web: www.scdfc.org www.campcrescentmoon.org

Release of Information

Information in this document is protected by HIPAA privacy laws and should be handled accordingly.
This form is only good for travel to and from, and attendance at Camp Gibbous; it may not be used for any other purpose. A new form must be completed annually for attendance.

For office use only
❑ Camper ❑ Volunteer
❑ Complete ❑ Incomplete
❑ Approved ❑ Pending
❑ Rejected ❑ ____________
Reviewed by: ____________
Date: _____/_____/_____

Note to Parent/Guardian: The Sickle Cell Disease Foundation of California (SCDFC) wants the camp experience to be a safe and healthy one. However in the event of an accident or illness, it is important that we have the following information.

1. **Proof of physical examination, verified by Physician's signature**
2. **Copy of Medical Insurance Information, and**
3. **Copy of Immunization record**

Please PRINT all information

Child's Name: ____ ❑ **Female** ❑ **Male**
Last First Middle

Date of Birth: ______/______/______ **Age:** ________ **Height**: ________ **Weight**: ________

Blood Pressure: ________ **Temperature:** ________ **Pulse:** ________ **Respiration:** ________

Laboratory: HB Electrophoresis Type: ❑ **SS** ❑ **SC** ❑ **S/Thal** ❑ **Other**: ____________

Latest Hemoglobin: ________ gm/dl **Hematocrit:** ________ % **Date:** _____/_____/_____

Baseline O2 Saturation on Room Air: ________ % **Date:** _____/_____/_____

Other Pertinent Lab Data: ________________________________

General Appearance: (Describe skin, sclera, etc.) ________________________________

____

____

Cardiomegaly: ❑ Yes ❑ No Murmur: ❑ Yes ❑ No Describe: ________________

Chest X-Ray: Date: ________ Normal: ❑ Yes ❑ No Describe: ________________

EKG: Date: ________ Normal: ❑ Yes ❑ No Comment: ________________

____

Spleen: Enlarged ❑ Yes ❑ No CM from LCM: ________________

Liver: Enlarged ❑ Yes ❑ No CM from RCM: ________________

Hernia: ❑ Yes ❑ No Umbilical: ________________ Inguinal: ________________

Has child had the following:

Condition		Comments	Condition		Comments
Asthma or Wheezing	❑ Yes ❑ No		Hay fever	❑ Yes ❑ No	
Avascular Necrosis	❑ Yes ❑ No		Kidney Disease	❑ Yes ❑ No	
Convulsions	❑ Yes ❑ No		Leg Ulcers	❑ Yes ❑ No	
CHF	❑ Yes ❑ No		Meningitis	❑ Yes ❑ No	
CVA/Stroke	❑ Yes ❑ No		Osteomyelitis	❑ Yes ❑ No	
Chronic Transfusion Program	❑ Yes ❑ No		Pneumonia	❑ Yes ❑ No	
Eczema or Skin Rashes	❑ Yes ❑ No		Recent Infection	❑ Yes ❑ No	
Gallstones	❑ Yes ❑ No	Symptoms ❑ Yes ❑ No	Other:	❑ Yes ❑ No	

Child's Name/Patient: ______________________________ **DOB**: _____/_____/______

ALLERGIES: Please list any **allergies** including reaction and treatment: (drugs, food, environment, poison ivy, insect stings, other): ❑ None ❑ Unknown ______________________________

____

Usual pattern of crisis: ______________________________

Does fever accompany crisis? ❑ Yes ❑ No

Recent crisis: ❑ Yes ❑ No Type: ______________________ Date: ______________

Number of days of usual crisis: ____________ Number of hospital stays last year: ______________

Reason for last hospitalization: ______________________________ Date: ____________

Operations & Dates: ______________________________

Does child take medications (prescribed, herbal, alternative, other, etc.)? ❑ Yes ***(if yes, list below)*** ❑ No

Please list ALL medications:

Medication	Dose	Frequency	Reason	Currently Taking
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

Menstrual Period: ❑ Yes ❑ No ❑ N/A Cramps: ❑ Yes No ______________________

Usual cycle of menstrual period (i.e., every 28 days): ______________________

Special considerations to be watched for such as allergy (i.e., reaction to food, penicillin or other drugs), bed wetting, constipation, fainting, sleep walking, etc.:______________________________

____

____

Emotional response to illness: ❑ Mild ❑ Moderate ❑ Severe ❑ None ______________________

History of emotional or behavioral disturbance: ❑ Yes ❑ No If yes, please describe: ______________

____

Diagnosed with **ADD**: ❑ Yes ❑ No **ADHD**: ❑ Yes ❑ No ______________________________

How long has child been your patient? ________ years ________ months

Hospital where child is usually admitted: ______________________ Phone: ( ) ____________

Form completed by: ______________________ Date of completion: ______________

Physician's Signature: ______________________ Date: __________ Print Name: ____________

Address: ______________________________ City/St/Zip: ______________________

Phone: ( ) ______________________ Fax: ( ) ______________________

PARENTS/GUARDIANS: Please complete this area BEFORE SENDING TO THE SCDFC

Parent's Name (print): ______________________ Signature: ______________________

Address: ______________________________ City/St/Zip: ______________________

Home Phone: ( ) ______________________ Work Phone: ( ) ______________________

Cell: ( ) ______________________ email: ______________________________