



Camp Braveheart Camper Application Form

Camp Braveheart camper application forms must be returned by **April 15, 2009**. There are a limited number of camper slots available.

Return application forms to:

Children's Healthcare of Atlanta, Attn: Shannon Chapman, Transplant Admin.
1405 Clifton Road NE, Atlanta, GA 30322

Call Shannon Chapman at 404-785-1822 or Cheryl Belair at 404-785-6735 or e-mail campbraveheart@choa.org if you have any questions or concerns.

Camp Dates: Sunday, June 7 through Friday, June 12, 2009

Camper Information

Camper's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Circle One: Male Female Age (at camp): _____

Current Grade in School: _____ Date of Birth: _____

T-shirt size (circle one): Youth: S M L Adult: S M L XL XXL

Parent/Guardian Information

Parent/Guardian Name (with whom child lives): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work: _____ Cell: _____

Email Address: _____

Name of parent(s)/guardian(s) who may pick camper up from camp or bus:

In Case of Emergency

Contact: _____

Relation to Camper: _____

Home Phone: _____ Work: _____ Cell: _____



Physician Assessment Form

This form MUST be completed by child's primary cardiologist. Also include a copy of your child's last clinic note.

Name: _____

Age: _____ Sex: _____ Diagnosis: _____

Vital Signs:

T: _____ HR: _____ BP: _____ RR: _____ Wt: _____

Baseline Pulse Ox: _____

Physical Exam

HEENT: _____

Skin: _____

Extremities: _____

Heart: _____

Lungs: _____

Abdomen: _____

Overall Assessment: _____

Concerns: _____

Past Surgical History: _____

Allergies (food, drug and other): _____

Diet Restrictions: _____

Physical Restrictions: _____

Developmental or Chromosome Disorders: _____

Physician is aware of and gives permission for camper to attend Camp Braveheart.

Physician Signature

Date

Time

Children need Children's

Camper Personal Information

Complete questions thoroughly. The more we know about your child, the better prepared we can be for the camp week.

The camper to staff ratio is 4 to 1, so unfortunately we cannot offer one-on-one care at camp at this time. If your child requires extra attention, contact the camp director immediately.

1. Has your child been to Camp Braveheart before?

Yes_____ No_____ **Other overnight camp?** Yes_____ No_____

2. Is your child able to function at his/her age level?

Yes_____ No_____

If no, explain (social, emotional, interacting with others): _____

3. Does your child have any developmental delays or chromosome disorders (e.g., Trisomy 21/ Down's Syndrome)?

Yes_____ No_____

If Yes, explain: _____

4. Does your child have any special bedtime or sleep habits?

Yes_____ No_____

If yes, briefly explain: _____

5. Does your child have any fears? _____

What helps when he/she gets scared? _____

6. Does your child have any physical limitations (check all that apply)?

- Needs help walking long distances (may use wagon or wheelchair)
- Wears leg braces
- Recent procedures or surgeries that would limit physical activity
- Other, please explain: _____

7. Does your child have any special care needs (check all that apply)

- Central line
- Drains
- Glucose monitoring
- Respiratory treatments
- Oxygen (at night or during the day)
- Feeding tube
- Feeding supplements (e.g., BOOST or Ensure drinks)
- Ostomy or catheter care
- IVF/TPN

If yes, provide an explanation including equipment, supplies and frequency of treatment. _____

Camper Personal Information continued

8. Does your child need help with personal hygiene activities (check all that apply)?

- Dressing
- Toileting/bed wetting (send sheets and a blanket instead of sleeping bag)
- Showering
- Eating
- Oral hygiene
- Personal hygiene

If yes, explain in detail what assistance will be needed. _____

9. Is there anything we should know about your child to help make camp a positive experience? _____

10. In the past 12 months, has the camper had any serious illness or injury requiring surgery or hospitalization (including transplant related)?

Yes _____ No _____

If yes, give date(s) and reason(s). _____

11. Does your child have any behaviors that we should know about? (i.e., trouble at school, fighting, following directions, problems with authority, etc.)

Yes _____ No _____

If yes, please explain: _____

Camper Insurance Information

Primary Care Physician Name: _____

Phone: _____

Primary Cardiologist Name: _____

Phone: _____

Medical Insurance Information

Name of Patient: _____

Name of Insured: _____

Relationship to Patient: _____

Company Name: _____

Policy Number: _____

Group Number: _____

Medicaid Number: _____

Please attach copies of Medicaid, Medicare and/or insurance card.

Children need Children's

Medication

Camper **MUST** bring enough medication for six (6) days. The medical staff will store any medications needed during camp. Campers will **NOT** be allowed to give themselves any medications or have any medications in the cabins.

Please send medications in their original containers.

Name: _____ **DOB:** _____ **Allergies:** _____ **Weight:** _____

Due to the large amounts of medications given at camp, it is most efficient to give out medications during meal times. However, we understand that this is not possible for all campers. If your child needs to be given a medication at a specific time, please list the time in the appropriate box (instead of choosing a meal time).

Name of Medication	Day of Week Med is given	Dose (mg) amount to give	Frequency	Check the Time Usually Given
Example: Lasix	Everyday	20 mg/ 2 ml	2 times a day	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> PRN
Example: Penicillin	Mon, Wed, Fri.	10 mg/ 1 tablet	1 time a day	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> PRN
				<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> PRN
				<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> PRN
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				<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> PRN
				<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> PRN

Consent Form

The following consent agreement must be signed by a parent or legal guardian of the minor child in order for the child to attend Camp Braveheart.

Your signature below indicates approval of the following:

1. In the event that my child, _____, participates at Camp Braveheart during the 2009 session, I hereby waive, release and discharge any and all claims for damages for death, personal injury or property damage which I may have, or which my hereafter accrue to me, as a result of my child's participation in the Camp's activities. This release is intended to discharge in advance Camp Braveheart and all of its agents, representatives, volunteers and employees from any and all liability, claims, costs, expenses and/or damages (collectively referred to as "liability") arising out of or connected in any way with my child's participation in the activities of the Camp, even though that liability may arise out of negligence or carelessness on the part of the persons or entities mentioned above.

I further understand that serious accidents occasionally occur during camp activities, and that participants in camp activities occasionally sustain mortal or serious personal injuries and/or property damage as a consequence thereof. Knowing the risks of Camp activities, nevertheless, I hereby agree to assume those risks and to release and hold harmless all of the persons or entities mentioned above whom (through negligence or carelessness) might otherwise be liable to my child or to me (or to my heirs or assigns) for damages.

2. Camp Braveheart and Children's Healthcare of Atlanta accepts no responsibility for the loss, damage or theft of your child's property.
3. Should you as a parent or guardian, during the camp session, leave your place of residence; you will advise the camp administration where you can be contacted in the event of an emergency.
4. In case of medical and/or surgical emergency, you authorize Camp Braveheart and Children's Healthcare of Atlanta medical staff to render to your child or to arrange for your child to receive any X-rays, anesthetic, medical, dental, surgical diagnosis, treatment, and hospital care which is deemed advisable by and it to be rendered under, the supervision of any physician, dentist or surgeon licensed to practice in the State of Georgia.
5. Camp Braveheart, Children's Healthcare of Atlanta and its representatives have absolute permission to use your child's image in a photograph that pertains to the lawful programs and activities of the Camp.

All information is correct so far as I know and the child herein described has permission to engage in all prescribed camp activities, except as noted by me and the examining physician.

Parent/Guardian Signature: _____

Print Name: _____

Date: _____ **Relationship to Camper:** _____

Camper's Name: _____