

# Camp Goodtimes West 2010 Camper Application Packet



Camp Goodtimes West

Dear Camp Goodtimes Campers,

It is time to apply for Camp Goodtimes Summer 2010! We are looking forward to a great time at camp this year during both of our week-long sessions out on Vashon Island.

Please note that each camper needs to have a separate completed application form.

**There is one form for Patients/Former Patients and one form for Siblings.**

Regardless of date of treatment, Patients and Former Patients need to have a completed medical form. **At this time, we are limiting attendance to one Sibling per Patient/Former Patient.**

The application form and the medical form are to be completed and returned by **April 30<sup>th</sup>, 2010.**

We look forward to receiving your application!

Sincerely,

The Camp Goodtimes Staff

***For your convenience, please follow the steps listed below:***

- Complete a separate application form for each camper (patient AND sibling)
- Please specify which camp you would like to attend OR if you are flexible and can attend either. Campers may attend only ONE session.
- Complete immunization history on ALL campers (including siblings) – we do not keep records from prior years. **Do not write “up to date”, specific dates are required**
- Please complete medication sheet for ALL campers needing medications at camp
- Please give medical form to your doctor or nurse practitioner for campers who are patients OR former patients.) Deadline date for medical form same as application form

***\* Consideration for acceptance cannot be guaranteed after deadline date.***

### ***Summer 2010 Dates***

***June Camp: June 27 – July 3, 2010***

***July Camp: July 25 – July 31, 2010***

***\*\*\*Deadline for all applications April 30, 2010\*\*\****

**Camp Goodtimes West  
American Cancer Society**

**2120 First Avenue North, Seattle, WA 98109**

**Direct: (206)674-4105 Toll Free: (800)729-1151 Fax (206)285-3469**

Email: [campgoodtimeswest@cancer.org](mailto:campgoodtimeswest@cancer.org) Website: [www.campgoodtimeswest.org](http://www.campgoodtimeswest.org)

## Camper Application Form – Patient/Former Patient

I am applying for:  June Camp  July Camp  Can go to Either

CAMPER'S NAME: \_\_\_\_\_ (Last) \_\_\_\_\_ (First) PREFERRED NAME \_\_\_\_\_

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ AGE AT CAMP: \_\_\_ GRADE IN SCHOOL (2010-2011) \_\_\_\_\_

GENDER: Male: \_\_\_\_\_ Female: \_\_\_\_\_ T-SHIRT: Child – M L Adult – S M L XL XXL

How many years has camper attended Camp Goodtimes? \_\_\_\_\_

CAMPER IS: Patient on treatment: \_\_\_\_\_ Patient off treatment: \_\_\_\_\_

Name of brother or sister also applying to camp (if applicable): \_\_\_\_\_

I would like an application for the "Leader in Training program" \_\_\_\_\_  
(16 and 17 year olds July Session Only)

### **CONTACT INFORMATION: Please complete all sections**

Parents or Legal Guardians:

\_\_\_\_\_

Home address:

\_\_\_\_\_

Street

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Numbers: Daytime: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Evening: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alternate Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work/Business Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Pager: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-Mail: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone Numbers: Daytime: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Evening: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alternate Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work/Business Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Pager: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-Mail: \_\_\_\_\_

For Office use only:

Received		Publicity Release	
Med Info Form		Insurance	
Participation/Notarized		Medical Update Form	
Code of Conduct		Camper Release	
Consent		Pick-Up Form	

**CAMPER NAME:** \_\_\_\_\_

**CANCER INFORMATION**

Diagnosis: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

Date Treatment Ended: \_\_\_\_\_

Relapse date (if any): \_\_\_\_\_

Date Treatment Ended: \_\_\_\_\_

**Weight** \_\_\_\_\_ lb / kg (Please circle appropriate measurement)

**Allergies** (medication, food, animal, insect, environmental, etc.) \_\_\_YES \_\_\_NO

If YES, please describe allergy and action required: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

***Please write in dates or Immunization history attached check box***   
***(THIS NEEDS TO BE PROVIDED YEARLY. WE DO NOT KEEP PAST RECORDS!)***

Immunization	Yes/No	Date
Tetanus		
Hepatitis B		
Hepatitis A		
Tdap/Dtap		
DTP		
Polio		
Polio booster		
Varicella (Chicken Pox)		
MMR		
MMR Booster		
HPV (Female only)		
Meningococcal		
Pneumococcal		

My child is not receiving some immunizations because of religious or ethical considerations  
\_\_\_ Yes \_\_\_ No \_\_\_ Does not apply.

My child is not receiving immunizations or immunizations are delayed because of cancer  
treatment? \_\_\_ Yes \_\_\_ No \_\_\_ Does Not Apply

\*\*\*Please notify Camp Director if your child contracts an infectious disease or is exposed within 4 weeks of camp (ex. chicken pox, H1N1, measles, etc.)\*\*\*

**PARENT RECOMMENDATIONS/RESTRICTIONS:**

Special Diet (ex. vegetarian, vegan, lactose intolerant, no peanuts, no pork) \_\_\_\_\_

Swimming/Diving: \_\_\_\_\_

Activity Level: \_\_\_\_\_

Psychological conditions \_\_\_\_\_

Any special considerations? \_\_\_\_\_

**CAMPER'S NAME:** \_\_\_\_\_

**Does Camper have:**

- Yes No Broviac/Hickman \_\_\_\_\_
- Yes No Port-a-cath \_\_\_\_\_
- Yes No PICC Line \_\_\_\_\_
- Yes No Ostomy \_\_\_\_\_
- Yes No Omayo/VPShunt \_\_\_\_\_
- Yes No Feeding tube (type): \_\_\_\_\_

Indicate past medical issues (other than cancer: ex. surgeries, major illness, broken bones)

\_\_\_\_\_  
\_\_\_\_\_

**SECONDARY MEDICAL CONDITIONS:** Circle any of the following conditions exhibited by your child. Please provide detailed information about his/her limitations. Do not hesitate to use an additional sheet to provide more information which would help us better understand your child.

- Yes No Visual Impairments: \_\_\_\_\_
- Yes No Hearing Impairments: \_\_\_\_\_
- Yes No Seizures: \_\_\_\_\_
- Yes No Learning Disabilities: \_\_\_\_\_
- Yes No Cognitively (Academically) Functions Below Age Level: \_\_\_\_\_
  
- Yes No Asthma: \_\_\_\_\_
- Yes No Diabetes: \_\_\_\_\_
- Yes No Frequent Ear Infections: \_\_\_\_\_
- Yes No Heart Defect/Disease: \_\_\_\_\_
- Yes No Bedwetting: \_\_\_\_\_
- Yes No Prosthesis: \_\_\_\_\_
- Yes No Bleeding/Clotting Disorders: \_\_\_\_\_
- Yes No Seizures: \_\_\_\_\_
- Yes No Sleepwalking: \_\_\_\_\_
- Yes No Motion/Sea-sickness: \_\_\_\_\_
- Yes No Others: \_\_\_\_\_

**SPECIAL ASSISTANCE WITH DAILY LIVING NEEDS:** Indicate any assistance needed by your child.

- Yes No Dressing/Showering: \_\_\_\_\_
- Yes No Eating: \_\_\_\_\_
- Yes No Bath-rooming: \_\_\_\_\_
- Yes No Walking From Place To Place: \_\_\_\_\_
- Yes No Needs Wheelchair Assistance (Describe): \_\_\_\_\_

**FOR FEMALE CAMPERS:**

- Has child ever menstruated? Yes No
- If not, has she been told about it? Yes No
- If so, is her menstrual history normal? Yes No

**CAMPER'S NAME:** \_\_\_\_\_

**CAMPER INFORMATION: - Parent Portion**

We would like to get to know a bit about your child before they come to camp. Please answer the following as thoroughly as possible. The information is used for both evaluation of acceptance to camp and camper placement. Information is shared with the camper's counselors prior to camper arrival to help promote the best camp experience possible. (Please use additional paper as needed.)

Has Camper ever been to Camp before? Yes No      Overnight Camp? Yes No

Is your child having any difficulties now physically or emotionally? If yes, please describe:

\_\_\_\_\_

\_\_\_\_\_

Please describe your child's special qualities (e.g. quiet, active, hobbies, interests, etc.)

\_\_\_\_\_

\_\_\_\_\_

Please describe any bedtime or sleep habits of your child and how they are handled at home.

\_\_\_\_\_

\_\_\_\_\_

Camp is filled with many activities (e.g. Swimming, fishing, bike riding, boating, archery, sports, crafts and many others.) Are there any restrictions on any of these activities? Please describe:

\_\_\_\_\_

\_\_\_\_\_

Is there anything you would like to tell us about your child that could enhance their camp experience?

\_\_\_\_\_

\_\_\_\_\_

**CAMPER INFORMATION – Camper Portion (To be completed by camper or with parental aid.)**

What excites you about coming to Camp Goodtimes?

\_\_\_\_\_

\_\_\_\_\_

What, if anything, concerns or worries you about coming to Camp Goodtimes?

\_\_\_\_\_

\_\_\_\_\_

The information given in this application and health history is true and accurate to the best of my knowledge. I give my permission for Camp Goodtimes staff to administer medications as needed and indicated by physician.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_





Camper Medical Information Form – Patient/Former Patient  
To be completed by physician or nurse practitioner

**Please complete and return by April 30, 2010 to:**

Camp Goodtimes West, American Cancer Society  
2120 First Avenue North, Seattle, WA 98109  
Fax: (206)285-3469  
Questions?: (206)674-4105/(800)729-1151

**PLEASE PRINT OR TYPE**

I have examined: \_\_\_\_\_  
(patient's name)

In my opinion, the above named person's condition does not preclude his/her attendance at camp.

Diagnosis and Disease Site: \_\_\_\_\_

Current Treatment Status (circle one):      ON      OFF

If on treatment:

Initial Diagnosis Date: \_\_\_\_\_  
Date of Recurrence: \_\_\_\_\_  
Current Chemotherapy: \_\_\_\_\_  
Line                      Yes      No      If yes, type \_\_\_\_\_  
VP Shunt or Omayo    Yes      No      \_\_\_\_\_  
Feeding Tube        Yes      No      \_\_\_\_\_  
Other/Complications   Yes      No      \_\_\_\_\_

If off treatment:

Date of Completion: \_\_\_\_\_  
Complications: \_\_\_\_\_  
Line                      Yes      No      If yes, type \_\_\_\_\_  
Feeding Tube        Yes      No      \_\_\_\_\_

If S/P BMT:

Date of BMT: \_\_\_\_\_  
Date of 2<sup>nd</sup> BMT: \_\_\_\_\_  
Line                      Yes      No      If yes, type \_\_\_\_\_  
Feeding Tube        Yes      No      \_\_\_\_\_  
GVHD                    Yes      No      \_\_\_\_\_

**CAMPER NAME:** \_\_\_\_\_

**ALLERGIES** Please list drug, food, or environment allergies and describe:

Medication	Reaction/Treatment Required

Varicella Immune:    Yes    No    Status Unknown

Camper on Chemotherapy at camp or within 72 hours of start of camp?    Yes    No

Additional Health Information Needs:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Nurse Practitioner/Physician's Name (Please Print): \_\_\_\_\_

Nurse Practitioner/Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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