



# Camp Warren Jyrch 2009 Application July 2009

Medical information to be completed and signed by a Hemophilia Treatment Physician

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age at Camp: \_\_\_\_\_

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

Street

Apt #

City

State

Zip

Gender: Male Female (circle one) Camper e-mail: \_\_\_\_\_

Custodial parent(s)/guardian: \_\_\_\_\_

Mother Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Father Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Second parent/guardian or emergency contact: \_\_\_\_\_

Home address: \_\_\_\_\_

(if different from above)

Street

Apt #

Phone

City

State

Zip

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

If not available in an emergency, notify:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Home address: \_\_\_\_\_

(if different from above)

Street

Apt #

Phone

City

State

Zip

## Insurance Information

◆ Photocopy of front and back of all health insurance cards MUST be included with this form.

Check all types that you currently have:

\_\_\_\_ Individual Policy \_\_\_\_ Medicaid \_\_\_\_ Medicare \_\_\_\_ DSCC / State Program \_\_\_\_ SSI

Subscriber Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Policy Number (9 digit Recipient ID number AND Case ID Number for Medicaid):

Carrier or Plan Name: \_\_\_\_\_ Group #: \_\_\_\_\_

## TRANSPORTATION

### New Campers

→ Parents of first year campers MUST provide transportation to and from camp for your child. If for some reason your child needs to leave camp early, YOU must provide transportation.

### Returning Campers

I will need assistance w/transportation for my camper  to Camp  from Camp

I am willing to provide transportation for other campers to and from Camp

Please contact me at ( ) \_\_\_\_\_



# Health History

Camper Name: \_\_\_\_\_

The following information must be filled in by the parent or guardian. The intent of the information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any change to this form must be provided to camp health personnel upon camper's arrival in camp. Provide complete information so that the camp can be aware of needs.

## ALLERGIES List all know.

## Describe reaction and management of the reaction

### Medication allergies

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### Food allergies

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### Other allergies (include insect stings, hay fever, asthma, animal dander, etc.)

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**MEDICATIONS BEING TAKEN:** Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the week of camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration. Attach additional pages for more medications.

Medication	Dosage	Special Instructions

\*Identify any medications taken during the school year that camper may not take at camp:

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## RESTRICTIONS: The following restrictions apply to this individual

### Dietary

- Does not eat red meat                       Does not eat pork                       Does not eat eggs  
 Does not eat poultry                       Does not eat seafood                       Does not eat dairy products  
 Other (describe) \_\_\_\_\_

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

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# Bleeding Disorder Information

Camper Name: \_\_\_\_\_

Hemophilia Treatment Center / Hematologist: \_\_\_\_\_

If not at an HTC, specify physical and medical institution: \_\_\_\_\_

Diagnosis:

\_\_\_\_\_ Factor Deficiency  
    \_\_\_\_\_ Factor VIII (Hemophilia A)  
    \_\_\_\_\_ Factor IX (Hemophilia B)  
    \_\_\_\_\_ Other factor deficiency: \_\_\_\_\_  
    \_\_\_\_\_ Other bleeding disorder: \_\_\_\_\_

\_\_\_\_\_ von Willebrand Disease  
    \_\_\_\_\_ Type I  
    \_\_\_\_\_ Type II: \_\_\_\_\_  
    \_\_\_\_\_ Type III

\_\_\_\_\_ Carrier Status  
    \_\_\_\_\_ Tested  
    \_\_\_\_\_ Untested

Level of Severity: \_\_\_\_\_ (Mild, Moderate, Severe)

Does your child have an inhibitor?    \_\_\_\_\_ Yes            \_\_\_\_\_ No

Does your child have a target joint?    \_\_\_\_\_ Yes            \_\_\_\_\_ No

If yes, which joints: \_\_\_\_\_

Significant Characteristics: \_\_\_\_\_

## TREATMENT INFORMATION

Name of Product: \_\_\_\_\_

Regular dose (# of units): \_\_\_\_\_

Other instructions?  
\_\_\_\_\_  
\_\_\_\_\_

Is your child on prophylaxis?    \_\_\_\_\_ Yes            \_\_\_\_\_ No

Prophylaxis dose: \_\_\_\_\_ I.U.

Prophylaxis schedule: \_\_\_\_\_

If your child is not on prophylaxis, how many times per month, on average does he receive factor?  
\_\_\_\_\_

Does your child receive factor at home?    \_\_\_\_\_ Yes            \_\_\_\_\_ No

If yes, does your child self-infuse?    \_\_\_\_\_ Yes            \_\_\_\_\_ No

Does your child have a port?            \_\_\_\_\_ Yes            \_\_\_\_\_ No

**General Information**

Camper Name: \_\_\_\_\_

Has / does the camper:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious diseases? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	14. Ever had high blood pressure? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/ condition? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever been diagnosed with a heart murmur? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (i.e. knees, ankles)? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems? (e.g. itching, rash, acne) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eyewear? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have abnormal menstrual hx? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
			27. Ever had an eating disorder? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
			28. Ever had emotional difficulties for which professional help was sought? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>

Please explain "YES" answers, noting the number of the questions

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Which of the following has your child had?

Measles                       Chicken Pox                       German Measles                       Mumps  
 Hepatitis A                       Hepatitis B                       Hepatitis C

**Please supply a copy of your child's most recent physical form with current immunization schedule with this application. Must be updated by physician within the last two (2) years. Campers will not be accepted without a current immunization schedule.**

Parent / guardian authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by camp to secure and administer treatment, including hospitalization, for the person named above.

Signature of parent / guardian \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

## REQUIRED CONSENTS AND SIGNATURE PAGE

Camper Name: \_\_\_\_\_

1. YES\*\*\* **RELEASE OF MEDICAL INFORMATION:** I AGREE TO TAKE MY CHILD TO OUR Hemophilia Treatment Center (HTC) for completion of the camp medical forms. I give my HTC permission to complete the camp medical form and release it to the Hemophilia Foundation of Illinois (HFI). HFI agrees to comply with all applicable confidentiality requirements and safeguards of medical information.
2. YES\*\*\* **MEDICAL TREATMENT:** I grant permission for my child to receive treatment for his/her bleeding disorder hemophilia and routine, nonsurgical care while at camp. In the event of a medical emergency, I grant permission for my child to be transferred to a medical facility for treatment at the discretion of the camp physician medical staff, and I will be responsible for all costs incurred for emergency or inpatient care. The medical staff may release medical information as deemed necessary.
3. YES\*\*\***MEDICATIONS:** I understand that I need to send an adequate supply of all of my child's factor and any other prescribed medications to camp.
4. YES\*\*\***CAMP PARTICIPATION AUTHORIZATION:** I give permission for my child to take part in all camp activities and educational activities about hemophilia and other inherited bleeding disorders, Hepatitis C and HIV related issues.
5. YES\*\*\***WAIVER:** In consideration of the benefits to be derived, I expressly waive all claims against the camp and its staff, the Hemophilia Foundation of Illinois, its officers, trustees and its employees, the National Hemophilia Foundation, the American Camping Association or their representatives on account of any accident, injury and/or illness that may occur to my child during camp.
6. YES\*\*\***FIRST YEAR CAMP TRANSPORTATION:** I agree to personally arrange/provide transportation to and from camp for my child. Should, for any reason, my child need to leave camp before the weeks end, I will arrange for his / her transportation.

**INITIALS:** PLEASE INDICATE YES OR NO TO THE CONSENTS **BELOW WITH YOUR INITIALS**

7. \_\_\_YES \_\_\_NO Should my child be hospitalized during camp, I hereby request that the Camp Medical Director, Doctor Lisa Boggio, or her representative, be included as a personal representative to receive information on my child's condition.
8. \_\_\_YES \_\_\_NO I authorize the medical Staff of Camp Warren Jyrch to release my child's medical information to his camp counselor and his supervisors. I understand that my child's medical information is shared with these staff members so that they can provide the best care and experience for my child while at camp.
9. \_\_\_YES \_\_\_NO **TRIPS:** I give permission for my child to take trips away from the campgrounds under direct staff supervision.
10. \_\_\_YES \_\_\_NO I give permission for any photographs or videos taken of my child at camp to be made available for use in promotional, educational, informational and/or news media. **If I have refused, I will discuss this with my child before camp begins.**

\_\_\_\_\_  
SIGNATURE OF PARENT / LEGAL GUARDIAN

\_\_\_\_\_  
DATE

## REQUIRED CONSENTS AND SIGNATURE PAGE

Camper Name: \_\_\_\_\_

11. YES\*\*\* RELEASE OF MEDICAL INFORMATION: I AGREE TO TAKE MY CHILD TO OUR Hemophilia Treatment Center (HTC) for completion of the camp medical forms. I give my HTC permission to complete the camp medical form and release it to the Hemophilia Foundation of Illinois (HFI). HFI agrees to comply with all applicable confidentiality requirements and safeguards of medical information.
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14. YES\*\*\*CAMP PARTICIPATION AUTHORIZATION: I give permission for my child to take part in all camp activities and educational activities about hemophilia and other inherited bleeding disorders, Hepatitis C and HIV related issues.
15. YES\*\*\*WAIVER: In consideration of the benefits to be derived, I expressly waive all claims against the camp and its staff, the Hemophilia Foundation of Illinois, its officers, trustees and its employees, the National Hemophilia Foundation, the American Camping Association or their representatives on account of any accident, injury and/or illness that may occur to my child during camp.

**INITIALS**: PLEASE INDICATE YES OR NO TO THE CONSENTS **BELOW WITH YOUR INITIALS**

16. \_\_\_YES \_\_\_NO Should my child be hospitalized during camp, I hereby request that the Camp Medical Director, Doctor Lisa Boggio, or her representative, be included as a personal representative to receive information on my child's condition.
17. \_\_\_YES \_\_\_NO I authorize the medical Staff of Camp Warren Jyrch to release my child's medical information to his camp counselor and his supervisors. I understand that my child's medical information is shared with these staff members so that they can provide the best care and experience for my child while at camp.
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\_\_\_\_\_  
SIGNATURE OF PARENT / LEGAL GUARDIAN

\_\_\_\_\_  
DATE



HEMOPHILIA FOUNDATION OF ILLINOIS
CAMP WARREN JYRCH 2009
Camper Medical Information

To Be Completed By A Hemophilia Treatment Center
Return No Later Than June 20, 2009

Confidential Patient Information - For Use by Camp Medical Staff Only

Mail completed form to: HFI; 332 S. Michigan Ave., Ste. 1135, Chicago, IL 60604

Camper Name \_\_\_\_\_

BLEEDING DISORDER INFORMATION

Diagnosis:

Factor Deficiency: Factor VIII (Hemophilia A), Factor IX (Hemophilia B), Other factor deficiency:
Other Bleeding Disorder

von Willebrand Disease:

Type I, Type II, Type III

Level of Severity: (Mild, moderate, severe)

History of inhibitor?: No Yes Most recent inhibitor titer: B.U. Date

History of a target joint? No Yes: (which joints):

Significant Characteristics:

TREATMENT INFORMATION

Name of product:

Regular dose:

Other instructions?

Is child on home treatment? No Yes

Is child on prophylaxis? No Yes

Prophylaxis dose: I.U.

Prophylaxis schedule:

Does the child have a port? No Yes

MEDICAL HISTORY

Hospitalizations within previous year? No Yes, specify

Surgeries within previous year?

Other Medical Problems:

Emotional/Psychological Problems:

**Camper Medical Information**

**Page 2**

**Camper Name:** \_\_\_\_\_

**Medications:**

**Dosage**

**Frequency**

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**Allergies:**

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**Physical Examination:**

**Date of exam:**

**Weight:**

**Abnormal physical exam findings:** \_\_\_\_\_

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**Abnormal joints (describe effusion, bony hypertrophy, ROM):** \_\_\_\_\_

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**Signature of person completing medical information:** \_\_\_\_\_

**Hemophilia Treatment Center:** \_\_\_\_\_

**Weekday phone #:** \_\_\_\_\_ **Emergency Phone #:** \_\_\_\_\_

*Based on my knowledge of this child's medical and psychological characteristics, I recommend for this child to attend HFI Camp.*

**Physician Name:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_

**Date signed:** \_\_\_\_\_

**HFI  
CAMP WARREN – CAMPER CONTRACT**

I plan to attend Camp Warren 2009. I understand that, for camp to be fun and safe for everyone, there must be some rules.

**During Camp I agree to the following:**

**To follow the written rules of camp and the instructions given to me by a staff member (Senior Counselor or Leader in Training (L.I.T.), Medical Staff, etc);**

**To participate enthusiastically in all camp activities and to help with other campers;**

To set an example for other campers around my health care – I will report all bleeds promptly for early treatment and take other medications as directed;

**To leave campgrounds only with a staff person for an approved activity;**

**To not bring any snacks, hand-held games, cell phones, pagers, iPods/MP3 players, electrical appliances, coffee pots, refrigerators, fans, fireworks, alcohol, cigarettes, knives, weapons or “street drugs” to camp;**

**To respect others at camp and not join in any activities which could be harmful to others or could damage property.**

**If anyone asks me to do something which doesn’t seem right, I know I can go to any staff member to talk about it.**

**I understand that, if I do not follow what I have agreed to, I could be kept out of specific activities or be sent home.**

\_\_\_\_\_  
**Camper Signature**

\_\_\_\_\_  
**Date**

**Reviewed by Counselor:**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**THIS FORM MUST BE SIGNED BY ALL CAMPERS AND  
BROUGHT WITH CAMPER TO CAMP!**

**IMPORTANT!**  
**PLEASE READ**



**Financial Form**

**Camp Warren Jyrch** is specifically designed to meet the special needs of children with hemophilia and other bleeding disorders. Our staff includes a highly qualified medical team on duty 24 hours a day, who are specially trained to provide hemophilia care. We also recruit counselors and staff who are familiar with bleeding disorders (many have bleeding disorders themselves). All work together to ensure that your child has a fun, memorable and safe experience, and you have piece of mind knowing your child is in good hands.

However, camp costs average in excess of \$1,000 per camper. The Hemophilia Foundation of Illinois is committed to providing quality camping experiences to children with hereditary bleeding disorders, regardless of financial restrictions of the family. We work year-round to raise funds and solicit donations from our Camp Partners and the community, yet we still fall far short of our needs. In order for us to continue to provide a quality program like Camp Warren Jyrch, we need your help.

**Our suggested camp fee is \$250.00/camper.** You can pay the entire fee now, or elect to defer 1/2 of the charges until June 30<sup>th</sup>, if you provide a credit card with an expiration date after June 30, 2009.

If you cannot pay the entire fee, please pay what you can or check here to talk with a member of our staff about financial assistance: \_\_\_\_\_

CAMPER NAME: _____ (Please use a separate form for each camper)	
Enclosed payment is by:    ( ) Check/Money Order    ( ) M/C    ( ) VISA    ( ) AMEX	
<b>Suggested camp fee:</b>	<b>\$250.00</b>
Amount enclosed:	
Amount to be charged with this registration form:	
Credit card number: _____	
Name on credit card: _____	
Expiration date: _____	
Amount to be charged on above card on 6/30/09: (card must expire after 6/30/09)	
<b>Total payment:</b>	

***You may also phone or fax credit card information.  
Please call 312-427-1495 or fax to 312-427-1602.***