



Please Note: You must have had a physical exam within a year of the program date.

Super Scientific Slumber Party with High Touch High Tech Saturday, January 14, 2012

Camper Name: _____ DOB: _____ Grade: _____

Camper Race: ___Caucasian ___African Am. ___Asian ___Am. Indian ___Hispanic ___Other

Diagnosis: _____ Date of Diagnosis/Relapse: _____

Please Check: ___On Therapy ___Off Therapy If off therapy, date therapy discontinued: _____

Treatment Hospital: _____ Primary Physician: _____

Special Concerns:

Allergies: _____

Dietary Restrictions: _____

Behavior: _____

Medication: _____

If you have been exposed to any communicable disease, particularly chicken pox, measles or mumps 1-3 weeks prior to the program, please contact us as soon as possible

Date of last Tetanus Shot _____ Have you had the chicken pox? _____ Varicella titer? _____

Name of Parent(s)/Guardian(s) with whom camper lives: _____

Relationship to child: _____

Address: _____

(street address) (city) (state) (zip) (county)

Home Telephone #: _____ Work Telephone #: _____

Cell #: _____ Parent email address: _____

If child does not live with both parents, please list other parent or guardian below:

Parent Name: _____ Relationship: _____

Address: _____

(street address) (city) (state) (zip) (county)

Home Phone #: _____ Cell Phone #: _____

Emergency Contact:

Name: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____

SPACE IS LIMITED: Applicants will be processed on a first come, first served basis, with priority to those campers currently on treatment.

Please return application by January 6, 2012:

Mail: Camp Sunshine, 1850 Clairmont Rd., Decatur, GA 30033 OR Fax: 404-325-7929

CAMP SUNSHINE 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 Sunshine's School Age Overnight.

Your signature below indicates approval of the following:

1. In the event that my child, _____, participates in the **School Age Overnight January 14, 2012**, 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 may 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 Sunshine 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 who (through negligence or carelessness) might otherwise be liable to my child or to me (or to my heirs or assigns) for damages.

I further agree to indemnify and hold harmless Camp Sunshine in the event any other person or entity, other than the undersigned, brings an action for the death or personal injuries of my child, _____, as a result of my child's participation in the Camp's activities.

2. Camp Sunshine accepts no responsibility for the loss, damage or theft of your child's property.

3. Should you as 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. If you have any health and accident insurance coverage, please list:

Name of insurance company: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of insured _____ Relationship to participant _____

Policy No: _____

If covered by Medicaid, please list Medicaid number _____

5. Notwithstanding Paragraph 1, I recognize and understand that Camp Sunshine is operated as a charitable organization. My child and I are receiving all of the benefits of Camp Sunshine with minimal or no costs to us and recognize that Camp Sunshine is immune from suit under Georgia's Charitable Immunity Doctrine.

6. In case of medical and/or surgical emergency, you authorize Camp Sunshine 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 is to be rendered under, the supervision of any physician, dentist or surgeon licensed to practice in the State of Georgia.

7. Camp Sunshine 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.

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

Signature: _____ **Date:** _____

Print Name: _____ Relationship to Camper: _____

Camper's Name: _____

Last Name _____

General Questions (Explain “yes” answers in the space provided below – use additional paper if needed)

Has your child / Does your child:

- | | | | |
|--|-----|---|-----|
| Had any recent injury or infectious disease? | Y N | Have a chronic illness/condition other than cancer? | Y N |
| Been hospitalized in the last 18 months? | Y N | Had surgery in the last 18 months? | Y N |
| Have frequent headaches? | Y N | Ever had a head injury? | Y N |
| Ever been knocked unconscious | Y N | Wear glasses, contacts or protective eye wear? | Y N |
| Ever passed out during or after exercise? | Y N | Ever been dizzy during or after exercise? | Y N |
| Ever had seizures? | Y N | Ever had chest pain during or after exercise? | Y N |
| Ever had frequent ear infections? | Y N | Have an orthodontic appliance? | Y N |
| Have a history of bed wetting? | Y N | Have ADD/ADHD? | Y N |
| (walker, crutches, wheelchair, prosthesis)? | Y N | Ever had high blood pressure | Y N |
| Ever been diagnosed with a heart murmur? | Y N | Ever had back problems? | Y N |
| Ever had problems with joints? | Y N | Have any skin problems (itching, rash, acne)? | Y N |
| Have diabetes? | Y N | Have asthma? | Y N |
| Had mononucleosis in the past 12 months? | Y N | Had problems with diarrhea/constipation? | Y N |
| Have problems sleepwalking? | Y N | Ever had an eating disorder? | Y N |
| Have a central line or port? | Y N | | |

Explain all “yes” answers:

If your child is on therapy, please send the most recent blood counts to overnight.

Please send all medications to camp with your child in their ORIGINAL CONTAINER with written instructions.

___ My child takes no medication on a routine basis.

___ My child takes the following medications on a routine basis (use additional paper if needed):

Drug Name	Dosage	Frequency

***Physician/Practitioner Statement and Recommendations**

I examined _____ on _____.

camper's full name

date of most recent examination

Weight _____ Height _____ BP _____

Last blood count: Hgb _____ Hct _____ WBC/ANC _____ Platelets _____

Medical recommendations and/or restrictions while on overnight:

In my opinion, the above applicant is able to participate in Camp Sunshine’s year round programs.

Physician or PNP Signature: _____ **Date:** _____

***Please note:**
 Physician/PNP signature required for on therapy campers or those who have not attended summer camp within one year from this program.