The Painted Turtle
17000 Elizabeth Lake Rd
Lake Hughes, CA 93532
Phone: 661-724-1550
Fax: 661-724-1566

Hemophilia Foundation
of Southern California
6720 Melrose Avenue
Los Angeles CA 90038
Phone : 323-525-0440
Fax: 323-525-0445

Hello parents and friends!

Camp sessions at The Painted Turtle are just around the corner and we're very excited to share yet another remarkable summer with all our campers.

So that we may provide the best care possible, we want to know as much as we can about your child before he/she arrives at camp. This means asking you to completely fill out the enclosed forms to help us thoroughly understand your child's specific medical and social needs.

Although we wish we could take every child who applies to camp, we may not have room for everyone to attend. We will let you know in June if your child will be attending camp. We're looking forward to a magical summer!

Ben Meisel, MD Medical Director	Blake Maher Camp Director	Linda Corrente Executive Director, HFSC

HEMOPHILIA, vWF & THALASSEMIA SESSION APPLICATION CHECKLIST
Camp Session July 10-15, 2008, for campers age 7-16

- **For the safety of all our campers, we require that all your child's immunizations are up to date. Please review the attached Immunization Requirements and arrange to have any necessary vaccines given.**
- Please schedule your doctor's appointment well in advance to ensure time for your doctor to complete the medical forms.
- When all forms are complete, please return to The Painted Turtle
  PO Box 455
  Lake Hughes CA 93532

FORM	DESCRIPTION
☐ Painted Turtle Camper Application	Contact / emergency information / medical information
☐ Authorization and Release Form	Safety/liability - Signature required
☐ Copy of Insurance card	Insurance information
☐ Physician's Medical Form	Physical exam by doctor
☐ Teacher Questionnaire	Child's profile

Check and return completed form <u>only if applicable:</u>

☐ Factor Infusion Consent (Hemophilia)

The entire completed application should be returned by <u>April 1 2008,</u> to be considered for a camp session. If you have any questions regarding the application, please contact the Hemophilia Foundation of Southern California at 323-525-0440, or The Painted Turtle, 661-724-1768 ext 202.

Camper Name ___________________________________ DOB_____________________

The Painted Turtle
2008 CAMPER APPLICATION

CHECK ONE SESSION

☐ **Liver Transplant & Arthritis/Rheumatic Disease**

☐ **Kidney Disease/Transplant** ☐ **Skeletal Dysplasia**

☐ **Hemophilia/vWF &Thalassemia** ☐ **Type I Diabetes**

TO BE COMPLETED BY PARENT OR GUARDIAN (Please print legibly.)

Camper's Full Name: ________________________ Goes by: ________________

Age at Camp: ________ Date of Birth: ____________ __ Male __ Female School Grade in 07-08: __________

Mailing Address: ____

City: ________________ State: ________ Zip: __________ County: __________

Home Phone: __________________ Email: ______________________

Camper's Primary Language: __ English __ Spanish __ Other: ________ Does camper speak English? Y / N

Camper's T-Shirt Size: (circle one) Youth S M L Adult S M L XL XXL

Parent / Legal Guardian

Full Name: ________________________ Relationship to Camper: ____________

Street Address: ____

City: ________________ State: ________ Zip: __________ County: __________

Home Phone: __________________ Work Phone: ______________________

Cell Phone: __________________ Email: ______________________

Parent / Legal Guardian **Check box ☐ if same as above**

Full Name: ________________________ Relationship to Camper: ____________

Street Address: ____

City: ________________ State: ________ Zip: __________ County: __________

Home Phone: __________________ Work Phone: ______________________

Cell Phone: __________________ Email: ______________________

With whom does the camper reside? Check all that apply.

__ Mother __ Father __ Stepmother __Stepfather If parents are divorced, who has legal custody? ______________

__ Brother(s); How many? _____ Sister(s); How many? _____ __ Other: ______________________________

Emergency Contacts

Please list ***TWO*** *adults (other than the child's parent or guardian) who, in the case of an emergency, The Painted Turtle may contact and/or turn your child over to if you are not available.*

Full Name: ________________________ Relationship to Camper: ____________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ____________

Full Name: ________________________ Relationship to Camper: ____________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ____________

Camper Name: ____DOB: _______________

Medical Provider Contact Information

Specialist: ____________________ Hospital: ____________________

Office Phone: ____________________ Office Fax: ____________________

Nurse/Coordinator ____________________ Office Phone ____________________

Pediatrician: ____________________ Office Phone ____________________

Dentist: ____________________ Office Phone: ____________________

Social Worker: ____________________ Office Phone: ____________________

Therapist: ____________________ Office Phone: ____________________

Other (specify): ____________________ Office Phone: ____________________

Insurance Information

NOTE: *You* ***<u>must</u>*** *ALSO include a* ***TWO-sided copy*** *of your insurance card (and a pharmacy card, if applicable.)*

Insurance Company: ____________________ Policy/Group Number: ____________________

Address: ____________________ Contact Number: ____________________

Name of Insured: ____________________ Relationship to Camper: ____________________

CCS # (if applicable): ____________________ Medicaid/Medi-Cal # (if applicable): ____________________

CCS Case Worker and Phone Number (if applicable): ____________________

Immunization Record

NOTE: *Please complete the fields in the box below OR attach a copy of your child's current immunization record.*

Dtap/DT/Tdap: ______ ______ ______ ______ ______ MMR: ______ ______

Date of Last Tetanus Booster (required every 10 yrs): ______ Pneumococal (PCV, Prevnar, Pneumovax): _____ _____ _____ _____ _____

Polio (IPV/OPV): ______ ______ ______ ______ Meningococcal: _____

Hepatitis B: _____ _____ _____ Hepatitis A: _____ _____ HIB/Hflu Vaccine: _____ _____ _____ _____

Varivax: _____ _____ <u>OR</u> Date child had chicken pox: _____________ Was it diagnosed by an MD? Y / N

TB Skin Test (optional): _______ CIRCLE Results: positive / negative If positive, explain treatment: ________________________

Check box ☐ if UNABLE to receive live vaccines

Treatment Record

	Date of Most Recent	Reason for Most Recent	Number in Past 12 Months
Doctor Visit			
ER Visit			
Hospitalization			
Surgery			

Camper Name: ____DOB: ________________

Medical History

Diagnosis: ________________________________ Date of Diagnosis or Transplant: ______________

Other Medical Conditions: Check any other medical conditions your child has.

__ headaches __ stomach aches __ constipation __ incontinence __ sinusitis __ PE/ear tubes

__ arthritis __ rash __ fissure __ vision loss __ hearing loss __ earaches

__ fainting __ palpitations __ hypertension __ diabetes __ immunodeficiency __ bleeding disorder

__ kidney infection __ urinary tract infection __ seizures; date of last: ___________ __ other: ______________________________

__ asthma; severity: __ mild __ moderate __ severe Is an inhaler used? **Y / N**

If female, has she begun her menstrual cycle? **Y / N** Typical treatment for menstrual cramps: ________________________

Comments: Please provide additional details regarding your child's primary medical condition and any other checked conditions.

Anatomy / Devices: Please place a check next to any anatomy or devices your child has. **Check box if NONE** ☐

__ ostomy __ G-tube __tracheostomy __ VP shunt : date last revised ________ __ hearing aids Other ______________

__ central line ___ portacath ___ dialysis catheter ___ fistula If checked, describe location: _________________

__ needs urinary catheterization If yes, How often _____________ Does your child self catheterize? Y / N

Comments: Please describe care for any of the above:

Behavioral/Emotional Conditions: Check any behavioral or emotional conditions that your child has been diagnosed with.

__ anxiety __ depression __ ADD/ADHD __ other: ____

- Has your child been **prescribed** any medication for the above-checked items? **Y / N**
- Has your child seen a **therapist or social worker** in the last 12 months? **Y / N**

Comments:

Current Medication Regimen

Oral Medications, Vitamins, Supplements: List ALL of the oral medications, vitamins, supplements your child is currently taking.

Drug Name	Strength/Concentration	Dose per Administration			
		Breakfast	Lunch	Dinner	Bedtime
Example Drug XYZ	10 mg	1 pill	NA	2 pills	NA

IV, Injections, Feeding Tubes: Include ALL, including those not taken daily

Drug Name	Strength/Concentration	Route	Dose	Frequency

PRNs: List any drugs that are only taken as needed, specifying the name of the drug and the corresponding dosage.

Medication: ______________________ Dosage: ______________________	Medication: ______________________ Dosage: ______________________	Medication: ______________________ Dosage: ______________________

Camper Name: ____DOB: ________________

Allergies

Check box if NONE □	Allergy	Reaction	Typical Course of Treatment
To Medication			□ Requires Epi-pen
To Food			□ Requires Epi-pen
To Other (pollen, horses, bees, latex, etc.)			□ Requires Epi-pen

Dietary Restrictions

Check box if NONE □

__ lactose intolerant __ vegetarian __ Celiac disease ____ Milk Protein __ Kosher __ other: _____________

Comments: Please offer additional insights regarding your child's dietary restrictions.

Daily Activity Participation

CHECK if your child requires significant assistance with any of the following. **CIRCLE** if total assisted care is required.

__ Daily Care (i.e. dressing, brushing teeth) __ Bathing/Showering __ Meals __ Toileting/Bathroom

Can your child walk 1/4-1/2 mile unassisted several times a day? **Y / N** Does s/he require any of the following?

__ Wheelchair __ Braces __ Splints __ Crutches __ Other: ___________________

Comments:

What is your child's swimming level? __ can't swim __ beginner __ intermediate __ advanced

Please list **ANY activities in which the camper CANNOT participate**, and explain why. See below for a sample list of activities.

Check box if NO RESTRICTIONS □

All activities are supervised and include but are not limited to: (*1) archery, (2) arts & crafts, (3) baking/cooking, (4) boating, (5) creative arts (writing & photo), (6) discovery (science & nature), (7) fishing, (8) gardening, (9) horseback riding, (10) outdoor camping and cooking, (11) performing arts, (12) ropes course & climbing wall, (13) sports & recreation, (14) swimming, (15) woodworking.*

Camper Profile

Camp/Sleep-away Experience: Has your child ever done any of the following?

__ attended a day camp attended Painted Turtle __ attended another sleep-away camp __ been away from home for 5 days

Is your child planning to attend another camp this summer? **Y / N** If yes, which one: ____

Comments:

Attitude about Camp: How does your child feel about attending the Painted Turtle this year?

__ nervous __ excited __ fearful __ hopeful __ resentful __ other:________________

Comments:

Personality Traits: Which characteristics best describe your child?

__ shy __ makes friends easily __ easily frustrated/angered __ participates well with others __ a leader __ a follower

__ sensitive __ competitive __ aggressive __ mature for age __ outgoing __ especially active

Comments:

Camper Name: ____DOB: _______________

Camper Profile (continued)

Bedtime: Please check any of your camper's bedtime habits, and describe any bedtime routines that might be helpful.

__ bedwetting __ fear of dark __ sleepwalking __ nightmares __ night terrors

__ difficulty falling a sleep __ difficulty waking __ snoring __ talks in sleep __ other: ____________

Comments:

Communication: Campers must be able to communicate their needs while at camp. Does your child have any special communication needs (sign language, spelling boards, etc.)?

Attitude about medical condition: Please check which, if any, medical condition-related issues are hardest for your child to manage/cope with.

__ peers/relationships __ body image __ adherence/compliance __ other: ___________________

Comments:

What are your child's special interests and hobbies?

In what situations does your child feel least comfortable? Most comfortable?

At times, all children can feel frustrated or angry. When your child is angry, how does s/he handle his/her anger? Any suggestions for helping your child in such situations?

What other challenges might your child's counselor encounter when working with him/her? How can your child be best supported in such situations?

Does your child have any unusual behaviors or fears? **Y / N** If yes, please explain.

Have there been any recent changes in your child's life, family, or living arrangements? Check all that apply.

__ death __ divorce __ moving __ custody issues __ change schools __ other: _________

Comments:

If you will not be at home/work while your child is at camp, where will you be and what number(s) can we use to contact you?

Please offer any additional information that may help us better serve your child.

Camper Name: ____DOB: ________________

Confidential Campership Information

The Painted Turtle is made possible through generous donations and grants from public and private organizations. Without these generous gifts, the cost for each camper to attend a week at camp would be approximately $2500. Please complete the following information, which helps our prospective donors evaluate our programs.

Camper's age: ______________________________ Zip code: ____________________

Ethnicity: ☐ American Indian ☐ Asian ☐ Black ☐ Filipino
☐ Pacific Islander ☐ White ☐ Hispanic ☐ Other

Please list each dependant in your household

Relationship to camper: ____________________ Age: ______ Gender: ☐ Male ☐ Female
Relationship to camper: ____________________ Age: ______ Gender: ☐ Male ☐ Female
Relationship to camper: ____________________ Age: ______ Gender: ☐ Male ☐ Female
Relationship to camper: ____________________ Age: ______ Gender: ☐ Male ☐ Female
Relationship to camper: ____________________ Age: ______ Gender: ☐ Male ☐ Female

Who are the primary income providers? ______________________________

What is the **TOTAL** number of persons residing in the home? ______________________________

Annual Family Income

Please check the amount closest to your family income:

☐ $0-$5000 ☐ $6,000-$8,000 ☐ $8,000-$10,000 ☐ $10,000-$12,000
☐ $12,000-$15,000 ☐ $15,000- $20,000 ☐ $20,000-$26,000 ☐ $26,000-$31,000
☐ $31,000-36,000 ☐ $36,000- $42,000 ☐ $42,000-$47,000 ☐ $47,000- $53,000
☐ Over $53,000

California County and Governmental Assistance

If you and your child(ren) receive assistance, please indicate below:

TANF: ☐ Yes ☐ No SSI: ☐ Yes ☐ No

How did you hear about The Painted Turtle?

Camper Name: ____DOB: _______________

The Painted Turtle

Authorization and Release Form 2008

Name of child who will be a camper at The Painted Turtle Camp:___________________________
(hereinafter referred to as the "Applicant")
Note: Please read the following information carefully. Every item on this page must be understood before signing. If there are any questions, please call The Painted Turtle at (661) 724-1550 for clarification.

Please initial each box below:

The Painted Turtle Camp is located at 17000 Elizabeth Lake Road, City of Lake Hughes, State of California (hereinafter referred to as the "Camp").

I certify that I am the parent or legal guardian of the above named Applicant. ☐

I understand that Applicant will be participating in many physical activities at the Painted Turtle Camp. All Camp activities are supervised.

Equestrian activities are conducted in a controlled riding arena. Our equestrian staff members are trained professionals, and the safety of the child is always paramount. Supervised, led trail rides may also be offered to children with parental/medical approval.

The Camp also provides a high and low ropes program that offers an adventurous opportunity and is supervised by professionally trained program staff. All participants wear the safety equipment provided, including helmets and harnesses.

The Camp's swimming program is supervised by professionally trained and certified life guard staff. The chlorinated and heated swimming pool has wheelchair accessible water entry and is universally accessible.

The Camp is in development of an organic gardening program that will involve campers digging in the soil and planting/harvesting flowers, fruit and vegetables at camp. Garden gloves are used for all gardening activities and edibles are washed thoroughly before cooking or consumption.

I specifically give permission for the Applicant to participate in the following supervised activities at the Camp: (a check mark in front of the activity means that you give permission for your camper to participate)

☐Horseback riding ☐Ropes program ☐Swimming (pool only) ☐Organic gardening

I give permission for Applicant to participate in all of the activities at camp.
Please note any exceptions here: ☐

I authorize the Camp medical staff to provide the Applicant with medical care which is deemed necessary by the Camp medical staff. ☐

I authorize the Camp medical staff to consent to any emergency medical care or treatment, including the dispensing of medicine, examinations, immunizations, x-rays, tests, dental care, anesthetics, medical or surgical diagnosis or treatments, and hospital care, to be rendered to the Applicant as deemed necessary by the Camp medical staff.
I also give consent for any transportation deemed necessary or appropriate, at the discretion of the Camp, in connection with the medical treatment of the Applicant. ☐

I assume financial responsibility for any and all medical and other expenses incurred for or on behalf of the Applicant while at the Camp or offsite. ☐

DIABETES CAMPERS ONLY: I authorize the Camp medical staff to provide the Applicant with medical care, which is deemed necessary by the Camp medical staff, including but not limited to the adjustments of insulin and diet as needed based on the decision of medical staff. Applicant may also participate in medical and dietary education and education about insulin administration and adjustment. ☐

Camper Name: ____DOB: _______________

I authorize Camp medical staff to release Applicant's medical records to Camp medical and non-medical staff and to third parties, for the purposes of Applicant's medical treatment, the non-medical care of Applicant, referral, billing, or insurance purposes, as deemed necessary by Camp medical staff. ☐

I authorize individual(s) listed as "emergency contacts" to pick up my child from camp or its bus stop and to authorize medical care. ☐

I authorize Camp staff to provide transportation to the Applicant, as needed, while the Applicant attends the Camp. I release the Camp from all claims, damages and liabilities that may result, directly or indirectly, from any injury that Applicant may suffer during such transportation. ☐

I authorize the Camp Director to return the Applicant to his/her home for any serious violation of the Camp rules. I agree that the Camp Director shall be the sole judge of what constitutes a serious violation. ☐

I understand that, in order for Applicant to attend the Camp, I must give up any rights to hold the Camp liable for any injury or damage, which the Applicant may suffer while attending the Camp or participating in the activities offered at the Camp. ☐

I voluntarily release the Camp, its officers, agents, and employees from any and all liability resulting from or arising out of the Applicant attending the Camp or participating in the activities offered by the Camp. ☐

I understand and agree that this Release will have the effect of releasing, discharging, waiving and forever relinquishing any and all actions or causes of action that I may have or have had, whether past, present or future, whether known, or unknown, and whether anticipated or unanticipated by me, arising out of the Applicant attending the Camp and/or participating in the activities offered by the Camp. This Release constitutes a complete release, discharge and waiver of any and all actions or cause of action against the Camp, its officers, agents, or employees. ☐

I understand and agree that this Release will be binding on me, my spouse, the Applicant, my heirs, my personal representatives, my assigns, my children and any guardian ad litem for said children. I understand and agree that by signing this Release, I am agreeing to indemnify and hold the Camp, its officers, agents and employees harmless from any and all liability or cost, including attorneys fees associated with or arising from the Applicant attending the Camp and/or participating in the activities offered by the Camp. ☐

I have read the above information carefully, and I have fully understood each item prior to initialing it. I understand that if I have any questions regarding anything contained in this Release, I may call The Painted Turtle at (661) 724-1550 for an explanation. ☐

I understand that as a condition of Applicant attending The Painted Turtle, the camp may use Applicant's name, photographs, other reproduction(s) and likenesses in connection with activities and publications of the Camp. The Painted Turtle respects the privacy of its campers and their families and does not allow unauthorized visitors to photograph its campers.

This Release has been executed as of ______________________________ , 200__.

Print Name: ____

Signature: ___________________________ Capacity (Parent, Guardian, etc.): _____________

The Painted Turtle
17000 Elizabeth Lake Rd, PO Box 455 • Lake Hughes, CA 93532
Phone: 661-724-1550 •Fax: 661-724-1566

Camper Name: ____DOB: ______________

The Painted Turtle

2008 Immunization Requirements

We are committed to the safety and health of all our campers, camper family members, and staff. If you have any questions regarding immunizations please call and speak with our camp medical staff at
661-724-1768.

- **For Summer Camp Sessions,** follow the guidelines outlined below and provide your child's immunization information with the summer application.
- **For Family Weekend Sessions**, we ask parents to please make sure each child's immunizations are up to date (appropriate for age) and attach a copy of the vaccination record for each child (under 18yrs) who will be attending.

Required Vaccines

- ***Measles, Mumps and Rubella (MMR)***

2 doses of MMR vaccine are required for camp.

- ***Varicella (chicken pox)***

It is vital that we know whether the camper is susceptible to varicella (the virus that causes Chicken Pox and Shingles).
We require Varivax immunization or a documented history of the chicken pox disease to attend camp.

Exceptions for Varicella and MMR vaccines

Campers who are unable to receive live vaccines, transplant recipients, children receiving chemotherapy within the last year or with a CD4 count less than 15% are exempt. Please provide this information on your application.

Positive titers (blood test that shows immunity) to varicella, measles, mumps, or rubella are also acceptable.

Because Chicken Pox or Shingles can be very serious to some of our campers,
DO NOT ATTEND CAMP IF THERE HAS BEEN CONTACT WITH A CHILD OR ADULT WITH Chicken Pox or Shingles IN THE 3 WEEKS PRIOR TO CAMP OR IF A RASH IS ACTIVELY PRESENT (within 2 weeks of vaccination) AT THE SITE OF RECENT VACCINATION.

- ***Tetanus***

Campers are required to have the initial series of 4 shots and the last booster must be 9 ½ years or less from the beginning of the camp session. If your child is due for a tetanus booster, we strongly recommend getting the Adacel or Boostix vaccine which gives protection against pertussis (whooping cough) as well.

- ***Polio***

Campers are required to have had this 4 shot series.

- ***Hepatitis B***

Campers are required to have had this 3 shot series.

Recommended Vaccines

- ***Hepatitis A and Meningococcal (Menactra) vaccines***

Hepatitis A vaccine is a 2 shot series for all children over 1 year of age. Meningococcal vaccine is recommended for all children over 11years old as well as for even younger children with immunodeficiencies like functional asplenia and complement deficiency.
In 2009 we will be requiring these for attendance.

- ***Flu vaccine***

Strongly recommended for campers and children attending the fall and winter family weekends. PLEASE DO NOT ATTEND IF YOU HAVE RECEIVED THE INTRANASAL FORM OF THE FLU VACCINE WITHIN 10 DAYS OF CAMP.

Applications will not be considered complete, and therefore will not be reviewed, until all immunization records are received. Thank you!

Camper Name: ____DOB: ________________

For Camp Med Staff: Prophy ☐ Meds ☐ Port ☐ Inhibitor ☐

Hemophilia/Bleeding Disorder Camp Session at The Painted Turtle Physician Form 2008

(To be completed by Bleeding Disorder Specialist)

Camper's Name:___________________________ Birth date: _____/_____/_______ Wt: __________kg/lb

HEMOPHILIA: (circle) **A** or **B** Severe Moderate Mild Carrier VIII_______% IX______ %

History of Inhibitors: ☐ Yes ☐ No Last Inhibitor test ___________ BU Date___________________

VonWILLEBRAND DISEASE: (circle) Type I II III Unknown Levels: VIIIC________% Rcof__________

Other COAG DX: ____

Problem Joints: ____

OTHER MEDICAL DX: ____

Other medical needs: ____

ALLERGIES: (circle one) None Unknown List : ____

CURRENT MEDICATION: (*parents to provide specific dose and schedule*)

____

____

<u>TREATMENT PRODUCTS</u>: for bleeding or prevention

Concentrate used (brand): ______________________ Routine dose: ___________ Units or: __________U/kg

DDAVP/Stimate used: ☐ Yes ☐ No IV SQ Intranasal Amicar used: ☐ Yes ☐ No

Approximate expected response to DDAVP: unknown or VIII =_______%

Using research product—Explain: ____

On immune tolerance—Explain: ____

Other: ____

Campers must bring an adequate amount for all treatments for the week at camp.
Camp supplies of concentrates will be used for emergencies only. All brands will not be available.

<u>FACTOR TREATMENT INSTRUCTIONS</u>:

Treat only "**as needed**" while at camp: ☐ Yes ☐ No

Give prophylaxis treatments at camp in addition to other treatments "as needed:" ☐ Yes ☐ No

Prophylaxis dose ______________ units on which days: (circle) Thur Fri Sat Sun Mon Tues
Camp dates July 2008 10 11 12 13 14 15

Other instructions:____

____

Central Line: ☐ Yes ☐ No (circle) Port PICC External /Other (type) ______________________

Is camper allowed to go swimming? ☐ Yes ☐ No
(Note: camp medical policy: once a Port has been accessed, campers may not swim the remainder of that day)

Instructions (please include before & after swimming care guidelines):________________________________

____

Camper Name: ____ DOB: ________________

PHYSICIAN EXAM: (Pertinent findings only)

HEENT	N	ABN ______________	Skin	N	ABN______________
Chest	N	ABN ______________	Extremities	N	ABN______________
Abdomen	N	ABN ______________	Other	N	ABN______________

CBC(if pertinent or abnormal):

______ WBC ______ Diff ______ Platelets ______ Date ________m/yr

MRSA Positive: ☐ Yes ☐ No If yes, date cleared: ____________ (may not attend unless cleared)
VRE Positive: ☐ Yes ☐ No If yes, date cleared:____________

Activity Restrictions? ____

Mobility issues (uses wheelchair, scooter, braces, etc): ____

Is the **child's development** appropriate for his/her age? ☐ Yes ☐ No If no, at what (approximate) age does child function? _____

Other Comments :____

PHYSICIAN / PROVIDER / CENTER INFORMATION: please check / complete as appropriate

☐ **CHLA** **(323) 669-4141** **F (323) 661-7453** **On Call (323) 660-2450**

☐ Director, Guy Young M.D. ☐ Edward Gomperts M.D. ☐ Thomas Hofstra M.D.
☐ Robert Miller PA ☐ Jennifer Donkin, R.N. CPNP ☐ N. Coordinator: Kathy McGinty, R.N.

☐ **CHOC** **(714)-532-8459** **F (714)-532-8771** **On Call (714) 765-6611**

☐ Director, Diane Nugent M.D. ☐ Geetha Puthenveetil M.D.
☐ Marianne McDaniel R.N. (714) 532-8762

☐ **City of Hope** **(626) 301-8858** **F (626) 301-8978** **On Call (626) 256-4673**

☐ Director Nadia Ewing M.D. ☐ Lisa Pullens R.N. (626) 301-8858 [8am-5pm M-Th]

☐ **Orthopedic Hospital** **(213) 742-1402** **F (213) 742-1103** **On Call (213) 742-1162**

☐ Director, Laurence Logan M.D (213) 742-1357 ☐ Doris Quon M.D.
☐ Rosemarie Atienza Santos R.N. ☐ Margarita Veres LVN ☐ Caesar Guerrero R.N (213)742-1404

☐ **Loma Linda** **(909) 558-2283** **F (909) 558-2176** **On Call (909) 824-0800**

☐ Christopher Morris,M.D.,PhD ☐ Fataneh Majlessipour,M.D ☐ Joan Morris,M.D.
☐ Albert Kheradpour,M.D. ☐ Antranik Bedros M.D. ☐ Liesel Mathias M.D.
☐ Pamela Kempert,M.D.

☐ **Long Beach** **(562) 492-1062** **F (562) 595-5296** **On Call (562) 492-1062**

☐ Paula Groncy,M.D. ☐ Jerry Finklestein, M.D. ☐ Ramesh Patel, M.D.
☐ Stanley Calberwood,M.D. ☐ Joetta Wallace RN, FNP (562) 933-0613
☐ Susan Shannon R.N,CPNP (562) 933-8622

☐ **Kaiser Fontana** **(909) 427-6126** **F (909) 427-4273** **On Call (888) 576-6225**

☐ Hushang Haghighat, M.D. ☐ Agnes Horvath, M.D. ☐ Janice Kirksey, R.N.
☐ Barbara Jeffries, R.N.

☐ **Other Physician:**
Physician Name:________________________________**Address:**________________________________

Phone ______________ **Pager**______________ **Fax** ______________ **Emergency Contact**____________

After Hours instructions ____

At Bleeding Disorder Camp at The Painted Turtle, my patient will receive needed medical service as determined and authorized by the Camp Medical Director.
Physician / Provider Signature: ____ **Date** _________

Printed Name: ____

The Painted Turtle
17000 Elizabeth Lake Rd., PO Box 455, Lake Hughes, CA 93532
Tel 661-724-1768 Fax 661-724-1566

Camper Name: ____ DOB: ________________

The Painted Turtle Camp
Transfusion-Dependent Thalassemia Session
Physician Medical Form 2008

(To be completed by MD, NP, or RN)

Name ______________________________________ DOB ____________ Date ____________

Primary Diagnosis/Type of Thalassemia? (Beta thal major, Hgb H, etc.): ______________________________
____

Date of Diagnosis: __________

Does the child have complications from iron overload? ☐ *Yes* ☐ *No* *(Heart failure, cardiac arrhythmias, diabetes, liver disease, etc.):* ______________________________
____

Is this child on a chronic transfusion protocol? ☐ Yes ☐ No
If yes, explain: ____

Date of most recent transfusion: ________________

History of allo/auto antibodies? ☐ Yes ☐ No Details: __________________________________

History of transfusion reaction? ☐ Yes ☐ No Details: __________________________________

Is child on Desferal? ☐ Yes ☐ No Schedule: __________________________________

If yes, the medical form for Desferal infusion must be completed - page 3.

Significant past medical history/Other conditions (may attach summary or last H&P): ____________________
____
____

Pertinent Major surgeries /dates (may attach summary): ______________________________
____
____

Last hospitalization:
Date: ____________ Diagnosis: ____

Problem List: (Please check all that apply)

☐ Pain in joints
☐ PE tubes
☐ Headaches(Frequent or Severe)
☐ Severe Visual Problems
☐ Splenomegaly (Spleen size_________cm)
☐ Tingling/Numbness in extremities

☐ Bleeding Risk
☐ Sleep Apnea
☐ Osteoporosis/Fracture Risk
☐ Recurrent GAStrep Throat
☐ Recurrent Skin Infections
☐ Asthma
___Mild ___Moderate ___Severe

☐ ADD/ADHD
☐ Enuresis
☐ Stool incontinence
☐ Diabetes
☐ Hypertension
☐ Seizures: Type ____________
Date of last:____________

Comments on any of the above : ____
____
____

Devices:
☐ PICC ☐ Portacath ☐ CVC Type/size ________________Location ____________
☐ Gtube ☐ Tracheostomy ☐Ostomy ☐ Oxygen:________________
☐ Other Device(s)____

Care Comments:____

Labs: **PLEASE ATTACH MOST RECENT or BASELINE LABS/STUDIES**

H/H_________ Retic_________ WBC_________ Plts_________ Date ____________

CXR ____ Date ____________

MRSA Positive: ☐ Yes ☐ No If yes, date cleared: __________ (may not attend unless cleared)
VRE Positive: ☐ Yes ☐ No If yes, date cleared:__________

Camper Name: ____DOB: ________________

Allergies List: (Medication, Food, and Other)____
____

Current Medications	Dose	Route	Frequency	Comments

Physical Exam:
Wt.:________ Kg / ________ lbs **Ht**: _______cm / ________in. **BP**: ______________ **HR**: ____________ **Date**: _______________

Significant physical findings at time of examination: (May attach recent H&P):

NML	ABNL		NML	ABNL	
☐	☐	HEENT____________________	☐	☐	Abdomen____________________
☐	☐	Hearing/Vision____________________	☐	☐	Kidney____________________
☐	☐	Neck____________________	☐	☐	Extrems____________________
☐	☐	Lymph____________________	☐	☐	Musculoskeletal____________________
☐	☐	Heart____________________	☐	☐	Neuro____________________
☐	☐	Lung____________________	☐	☐	Skin____________________

Current Medical Issues: ____
____
____

Vaccines:
Immunizations Up To Date: ☐ Yes ☐ No
Live Vaccines Deferred: ☐ Yes ☐ No
Has the camper had chicken pox? ☐ Yes ☐ No If Yes, What Year_________________

Important Camp Information:

Special dietary needs/food restrictions? (include TPN and/or Tube Feeding)_____________________________
____

Activity restrictions/limitations? Considerations? (We will not offer contact sports at the camp):___________________
____
____

May this child participate in our adaptive horseback riding program? ☐ Yes ☐ No
May this child participate in supervised pool swim? ☐ Yes ☐ No
May this child participate in a harnessed high ropes program? ☐ Yes ☐ No

Mobility issues (uses wheelchair, scooter, braces, etc): ____
____

Developmental Age:
Is the child's development appropriate for his/her age? ☐ Yes ☐ No
If No, at what (approximate) age does child function? _________

Behavior:
Any behavior problems that would affect child's participation in a group? _______________________________
____

Overall Recommendation:

This child is medically cleared to attend camp: ☐ Yes ☐ No
Comments: ____
____

Physician Signature: ____ **M.D.** **Date:**_____________________

Printed Name: ____

Form Completed by ____ **RN, NP** **Phone:** ____________________

Camper Name: ____DOB: _______________

CV Catheter and Desferal Infusion Form

Complete only if child has a central line and/or Desferal Pump
TO BE COMPLETED BY HEALTH CARE PROVIDER (PHYSICIAN/NURSE)

INSTRUCTIONS FOR CATHETER CARE **Fill out this section only if this child has a central line (i.e. Hickman, Broviac, Portacath, PICC)**	
Type of Catheter(Single/Double Lumen; Hickman, Broviac, Groshong, PICC, Portacath	**Date it was inserted**
Specific instructions for Catheter care:	
How often is it flushed with Heparin?	
Amount & Strength of Heparin?	
How often is dressing changed?	
When is cap changed? (Days of week)	
Special Instructions:	

All necessary supplies (dressing kits, heparin, syringes, access needles, EMLA, etc.) must be sent to Camp with each child. Children will need 7 dressing kits (or equivalent supplies) if they plan on swimming every day.

CENTRAL LINE CONSENT-Unless otherwise specified, all children will be permitted to swim.

This child: ☐ DOES ☐ DOES NOT have permission to go swimming in a chlorine-treated swimming pool.
(Dressings will be changed immediately following swimming)

____
Physician's Signature

INSTRUCTIONS FOR DESFERAL INFUSION PUMPS
COMPLETE THIS SECTION ONLY IF THIS CHILD WILL BE RECEIVING DESFERAL **AT CAMP**

MRSA Positive: ☐ Yes ☐ No If yes, date cleared: ____________ (may not attend unless cleared)
VRE Positive: ☐ Yes ☐ No If yes, date cleared:____________ (may not attend unless cleared)

Procedure for Mixing and Administering Desferal:	
Desferal Dose:	Hydrocortisone Dose:
Amount of sterile water:	
Length and rate of infusion:	
Number of nights Desferal to be administered while at camp:	
Does this child EMLA/ELA?	Does this child place his/her own needle?
Homecare company Name and Phone Number:	

All supplies including medication, needles, syringes, batteries must come to Camp with each child.

Manufacturer and model of pump:____

Telephone number to call for service or replacement:________________________________

The Painted Turtle
17000 Elizabeth Lake Rd., PO Box 455
Lake Hughes, CA 93532
Tel 661-724-1768 Fax 661-724-1566

Camper Name: ____DOB: ________________

Child's name: ___________________ DOB: _______________
Teacher's name: _____________________________________
Phone number: ______________________________________

Teacher Questionnaire

This child has applied to attend The Painted Turtle, a medical specialty summer camp. Your supplying the following information will help us provide the most positive experience possible for our campers. Teachers often have keen insight into how kids interact with their peers, accept direction/discipline, express their frustrations, learn and understand, and most importantly what it is they enjoy doing. Thanks for taking the time to help us! Please return this form to the parent when complete.

1. Please give a brief description of the child (outgoing, shy, easily frustrated, a leader/follower).

2. What are the child's strengths and in what areas does the child feel the greatest success?

3. What kinds of challenges does the child encounter while in school?

   What have you found to be the best way to help him/her resolve these challenges?

4. What grade is this child currently in?

   Does she/he work at that grade level?

   Does she/he receive any special tutoring?

   Does she/he have any learning disability?

5. Is there any information that has not been covered that you feel would be helpful to us? (i.e., recent changes in the child's world, life stressors, difficulty in school, difficulty with peers, etc.)

Teacher's signature: ________________________ Date: ______________

Parent's signature: _________________________ Date: ______________

Teacher Questionnaire 2008 (2)

The Painted Turtle
17000 Elizabeth Lake Rd., PO Box 455
Lake Hughes, CA 93532
Tel 661-724-1550 Fax 661-724-1566

Camper Name: ____DOB: _______________

Self Infusion Instruction Consent

The Hemophilia / Bleeding Disorder Camp at The Painted Turtle will be offering self-infusion instruction to Campers on a voluntary, informal and individual basis by trained medical staff. Your child/ward could receive training when he/she needs treatment during camp, but only if the child is voluntarily ready to infuse himself/herself.

I hereby consent to have my child/ward receive Self-Infusion Instruction ☐ Yes ☐ No

Parent/Guardian signature: ___________________________ Date: ___________________

Factor Usage Consent

I want my child/ward to use only physician designated factor while at The Painted Turtle, and I will be responsible for supplying an adequate amount of factor for the week of camp. I understand every effort will be made to give my child only his/her designated factor, however I realize the possibility exists that an unusual medical emergency may require that my child use donated factor. If this situation occurs, I understand that the Camp Medical Staff will authorize the appropriate factor usage, which will be fully documented in my child's medical log.

I hereby consent to the use of donated factor for my child ☐ Yes ☐ No

Parent/Guardian signature: ___________________________ Date: ___________________

If your child is due to receive a factor infusion treatment on Thursday, the first day of camp, please be sure to <u>infuse at home before arrival at camp.</u>

Hemophilia Factor-Infusion Consent 2008 (2)

The Painted Turtle
17000 Elizabeth Lake Rd ● Lake Hughes, CA 93532
Phone: 661-724-1550 ●Fax: 661-724-1566