

For Office Use Only
Received Application:

Camp Quality USA, Inc.

Camper Application Form (Patient Application)

Parents, please print and complete application in black ink.

Camp Dates: **Sunday, June 21 - Friday, June 26, 2009**

Name of Camp: **Camp Quality New Jersey**

**PLEASE RETURN THIS FORM TO: Camp Quality New Jersey
PO Box 264
Adelphia, NJ 07710**

General Information:

Camper Name		<input type="checkbox"/> Male <input type="checkbox"/> Female
Address		
City	State	Zip
Birth Date	Age	
Home Phone	Email	
Mother's Name	Cell Phone	Work Phone
Father's Name	Cell Phone	Work Phone
Legal Guardian	Cell Phone	Work Phone

Personal Information:

Shirt Size: [Child <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L] [Adult <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> X-L <input type="checkbox"/> XX-L]
Does the camper speak multiple languages? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, what language(s)?

Personality and Interests:

Describe the camper's personality and interests.
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Diet:

What are the concerns/likes regarding appetite or special food?

Activities:

Please list any special activity interests of which we should be aware:

Companion:

Each child attending camp is assigned a personal companion. He/She will accompany the child in all activities and programs of the camp. If your child attended Camp Quality last year, would he/she like the same companion? <input type="checkbox"/> Yes <input type="checkbox"/> No.
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Camper Agreement:

Companions and staff of Camp Quality camps have always been required to initial and agree to abide by some basic guidelines before they are permitted to serve at camps.

Because of past sad experiences when campers and staff have been subjected to verbal abuse and some campers placed at risk by the inappropriate behavior of a few campers, it is necessary for us to add this form, asking campers to agree to abide by guidelines.

We ask that campers initial each line and together with a parent, sign and then return this form to Camp Quality.

If a camper or parent would like to discuss any of these rules with me, please don't hesitate to call the Camp Director: Frank Dalotto - Camp Quality Director at (732)780 - 1409.

I understand and agree to the following rules:

- I will not bring cigarettes, alcohol or illegal drugs to camp.
- I will not bring knives or other potentially dangerous items to camp.
- I will not swear or use foul language at camp.
- I will follow the Camp Director's instructions regarding any out of bounds areas.
- I will observe designated quiet times so that all may get adequate rest.

Signature of Camper

Signature of Parent/Legal Guardian

Parent Certification:

Release for Promotional and Media Purposes

I give permission for my child's photographs, statements, artwork, and interviews, to be used by Camp Quality USA, Inc. for purposes of promotion, media release or both. Please note that media interviews are always conducted under Camp Quality staff supervision and only if the child is willing. Yes No.

Camp Attendance

I agree to my child's attendance at the above-mentioned Camp Quality and to his/her taking part in any excursions and/or activities arranged for the children in connection with the program. In consideration of the opportunity and privilege of attending Camp Quality, I hereby knowingly, freely and voluntarily release Camp Quality USA, Incorporated and its Board of Directors from any and all liability, claims, demands, actions and causes of actions whatsoever arising out of or related to any loss, damage or injury that my child may sustain while present at any Camp Quality activity.

Signature/Consent _____
(Parent or Guardian)

Date _____

Camp Quality USA, Inc. – Insurance/Contact Info.

TO BE COMPLETED BY PARENT OR GUARDIAN (ONE FOR EACH CHILD)

Camper's Name _____

Date of Birth ____/____/____

PHYSICIAN CONTACTS	
Hem/Onc Doctor:	Pediatrician/Other Doctor:
Hospital/Clinic:	Hospital/Clinic:
Address:	Address:
Daytime Phone: ())	Daytime Phone: ())
Emergency Phone: ())	Emergency Phone: ())

EMERGENCY CONTACTS (other than parent/guardian)	
#1 Emergency Contact Name:	Relationship:
Day Phone ()) Cell ())	Night Phone ())
#2 Emergency Contact Name:	Relationship:
Day Phone ()) Cell ())	Night Phone ())
Are the above contacts authorized to pick up your child if needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

INSURANCE INFORMATION	
Name of Insurance Provider:	Name of Insured:
Policy/ID #	Relationship to Camper:
Group #:	SSN of Insured:
Camper SSN:	Insurance Co. Telephone #: ())

PLEASE ATTACH A PHOTOCOPY OF YOUR INSURANCE CARD TO THIS FORM

Consent for Medical Treatment, Waiver and Release

I hereby grant permission to the medical staff at Camp Quality (CQ), or such designees as the medical staff may appoint, to provide routine or emergency medical care required for my child including, without limitation, medications, immunizations, x-rays, dental care, minor surgical procedures, hospitalization, general anesthesia, or other medical treatment as may be appropriate while the child is in the care of CQ. I understand that prior notification of the parent/guardian will always be attempted, but that the care of my child may require action by the medical staff before I can be contacted. I also give my consent for any transportation deemed necessary, at the sole discretion of the staff of CQ, in connection with the treatment of my child. I also assume full financial responsibility for any and all medical and other expenses incurred on behalf of my child while at CQ in connection with medical or other treatment, and acknowledge, agree and understand that CQ shall not be liable for any such expenses. I understand that all information pertaining to my child will be treated as confidential by CQ, but that said information may be shared with or released to appropriate personnel and/or third parties by CQ for the purpose of treating and/or supervising my child (including, but not limited to medical staff, psychological staff, insurance companies, and/or that child's companion). Finally, I agree to release CQ, its sponsors, medical care volunteers, employees, officers, directors, and agents of any liability arising from the administration or rendering of medical care.

I FULLY UNDERSTAND AND AGREE TO THE TERMS STATED ABOVE AND AGREE THAT ALL INFORMATION IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Parent/Guardian Signature _____ Date ____/____/____

Camp Quality USA, Inc. – Medical History

General Medical History (**Cancer Patient**) - TO BE COMPLETED BY PARENT OR GUARDIAN

Camper's Name _____

Date of Birth ____/____/____

IMMUNIZATIONS/ALLERGIES
Date of last tetanus shot ____/____/____
Has he/she had the chicken pox <i>vaccine</i> ? Yes <input type="checkbox"/> No <input type="checkbox"/>
Has he/she had the chicken pox <i>disease</i> ? Yes <input type="checkbox"/> Year _____ No <input type="checkbox"/>
Drug or Food Allergies:

The following information will be used to best pair your child with an adult companion.
Please check all that apply.

OTHER HEALTH CONCERNS	PHYSICAL RESTRICTIONS OR LIMITATIONS
<input type="checkbox"/> Asthma	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Seizures	<input type="checkbox"/> Migraines
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hives
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Emotional Concerns
<input type="checkbox"/> Developmental Delays	<input type="checkbox"/> Other (list below)
	<input type="checkbox"/> Wheelchair
	<input type="checkbox"/> Crutches/cane
	<input type="checkbox"/> Splint
	<input type="checkbox"/> Hearing Impairment
	<input type="checkbox"/> Visual Impairment
	<input type="checkbox"/> Artificial Limb/Amputation

Additional Notes: _____

LEVEL OF ASSISTANCE. Please place a <input checked="" type="checkbox"/> in the appropriate columns				
	Independent	Close Supervision	Moderate Assistance	Total Care
Daily Care (brushing teeth, dressing)				
Meals				
Bathing/Showering				
Toileting/Bathroom				

Additional Notes: _____

INSTRUCTIONS FOR CATHETER CARE	
Fill out only if this child has a central line (i.e. Hickman, Broviac, Groshong, PICC, Infusaport, Portacath, Mediport)	
<input type="checkbox"/> NO CATHETER	<input type="checkbox"/> Catheter type:
How often is it flushed?	_____ml of _____unit Heparin and/or _____ml of Normal Saline
How often is dressing changed?	When is cap changed?
Special Instructions:	

Please send central line dressing change & flushing supplies to camp with child

Parent/Guardian Acknowledgment: I have been informed of Camp Quality and request that my child attend. The above information is correct to the best of my knowledge & belief. In my opinion this child is physically & mentally capable of attending Camp Quality.

Parent/Guardian Signature _____ Date ____/____/____

Camp Quality USA, Inc. – Physical Exam Form

Physical Exam Form (Cancer Patient) - TO BE COMPLETED BY HEALTH CARE PROVIDER

Camper's Name _____ DOB ____/____/____ Date of Exam ____/____/____

MEDICAL INFORMATION	
Primary Diagnosis:	Date of Diagnosis:
Additional diagnosis:	
On Therapy? Yes <input type="checkbox"/> No <input type="checkbox"/> →	If yes, date of last treatment:
Off Therapy? Yes <input type="checkbox"/> No <input type="checkbox"/> →	If yes, date off therapy:
Allergies:	Any activity restrictions?
<input type="checkbox"/> Immunizations are up-to-date	<input type="checkbox"/> Immunizations are NOT up-to-date due to medical exemption and/or treatment

BASELINE VITAL SIGNS	LAB RESULTS
Temperature:	WBC:
Blood Pressure: /	ANC:
Pulse:	Hgb/Hct:
Respirations:	Platelet Count:
Height:	Additional Lab:
Weight:	Date of lab results:

BASELINE PHYSICAL EXAM. Please place a <input checked="" type="checkbox"/> in the appropriate column					
NML	*ABNL		NML	*ABNL	
		HEENT			NEURO
		ABDOMEN			HEARING/VISION
		HEART			LUNG
		SKIN			MUSCULOSKELETAL

* If abnormal, please describe below:

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

This child: DOES DOES NOT have permission to swim in a chlorine-treated swimming pool.

This child: DOES DOES NOT have permission to swim in a freshwater lake.

(Dressings will be changed immediately following swimming.)

This child does not have a central line

PHYSICIAN SIGNATURE

Physician Acknowledgement

I have been informed about Camp Quality and the request of my patient to attend. The items are correct to the best of my knowledge and belief. In my opinion this patient is physically & mentally capable of attending Camp Quality.

Physician's Signature _____

Date _____

Physician's Name (Please Print) _____

Phone _____

Camp Quality USA, Inc.

Camper Information Form

Camper: This form will be sent to your companion. After you fill it out, give it to your parents so they can send it in with your registration form.

Parents: Please add any information you feel would be helpful.

My name is (first and last)

I like to be called (first and last)

My parents names are

I am _____ years old and my birthday is

I live at

My telephone number is () -

My email address is

I go to _____ school and am in the _____ grade.

My favorite subject is

This will be my _____ (first, second...) camp, and I am especially looking forward to

My favorite color is

My hobbies are:

My favorite TV show is

My favorite TV stars are

The sport I like the best is

My favorite sports star is

I like the music of

My favorite food is _____ and I have a _____ appetite.

I have _____ brothers and _____ sisters.

Their names and ages are:

	age		age
	age		Age

I would like my companion to know

If I have a photo of myself, I will attach it to this form so you will know what I look like. See you at camp!

Camp Quality USA, Inc. – Medication Form

TO BE COMPLETED BY PARENT OR GUARDIAN (ONE FOR EACH CHILD)

****Fill out & bring to registration, so medications will be current.**

Do NOT return with application! **

Camper's Name _____

Date of Birth ____/____/____

- NO scheduled medications**
- Medications listed below: (please bring medications in original container)**

MEDICATIONS

Medication Name	Dose <small>mg, mcg, ml, etc.</small>	Route (by mouth, IV or injection)	Breakfast	Lunch	Dinner	Bedtime	Other <small>(time?)</small>	Comments
<i>Example: Bactrim</i>	<i>500 mg</i>	<i>by mouth</i>	<i>x</i>	<i>x</i>	<i>x</i>			<i>On Wed & Sun only</i>

- Over-the-counter medications that may NOT be administered (tylenol, aspirin, etc.)** _____

Parent/Guardian Acknowledgment

I authorize the health care team of Camp Quality USA, Inc. to administer the medications above as I have indicated. These medications are correct to the best of my knowledge.

Parent/Guardian Signature _____

Date ____/____/____

Reviewed by _____

Date ____/____/____