CAMP RED SUNRISE
CAMPER REGISTRATION FORM
Idaho Chapter, National Hemophilia Foundation

Return Registration
Idaho Chapter, National Hemophilia Foundation
3989 E 170 N
Rigby, Id. 83442

In order for your family to attend Camp Red Sunrise all information on this form must be completed and signed by a parent/legal guardian. If anyone's condition changes after you submit this form, please contact the Chapter: idaho@hemophilia.org

Failure to do so will prevent camp attendance.

PARENTS OR LEGAL GUARDIANS:

Last Name: First Name:

Last Name: First Name:

CONTACT INFORMATION:

Address:

Phone:

Email:

Family members who will be at camp:

Full Name: _____ Age:___ DOB: _____ Gender: ___ T-shirt Size___

Full Name: _____ Age:___ DOB: _____ Gender: ___ T-shirt Size___

Full Name: _____ Age:___ DOB: _____Gender:___ T-shirt Size___

Full Name: _____ Age:___ DOB: _____Gender:___ T-shirt Size___

Full Name: _____ Age:____ DOB: _____Gender:___ T-shirt Size___

Full Name: _____ Age:____ DOB: _____ Gender: ___ T-shirt Size___

EMERGENCY CONTACT INFORMATION:

First Contact Name: Relationship to Family:
Phone: _____
Second Contact Name: Relationship to Family:
Phone: _____

DIETARY INFORMATION:

Dietary information will be shared with camp staff and the camp nurse to facilitate planning for camp and to help make your experience at camp enjoyable. Note, that you will still need to monitor your family's own dietary allergies and restrictions while at camp. Any concerns should be taken to the camp co-directors or the camp nurse.

Food allergies: [List the name of the individual and the allergy.]
NONE_____
_____
_____
_____
_____
_____
_____
_____
_____

Dietary Restrictions: [List the name of the individual and the restriction.]
NONE_____
_____
_____
_____
_____
_____
_____
_____
_____

FAMILY MEDICAL FORM

The Family Medical Form is required for all individuals to all who attend Camp Red Sunrise.

Family Physician Name:_____Phone No.:_____

Family Dentist Name: _____Phone No.:_____

Specialist Name: _____Phone No.:_____

INSURANCE INFORMATION:
Name of Policy Holder:
Policy No.:
Insurance Company:
Social Security No. of Policy Holder:
Group No.:

Family Member Name/age _____-

CURRENT OR RECURRING MEDICAL CONDITIONS FOR ANY FAMILY MEMBERS:

This information is needed so medical staff can better care for you and/or your children while at camp. Please indicate which family member(s) any checked box applies to:

_____ Physical Injuries
_____ Skin Problems
_____ Diabetes (attach diet)
_____ Liver Disease
_____ Bedwetting
_____ Asthma or other
_____ Breathing problems
_____ HIV
_____ Heart Problems
_____ Hemophilia

_____ Hay Fever
_____ Vision Problems
_____ Ear Tubes
_____ Chronic diarrhea
_____ Hearing Problems
_____ Emotional/behavioral or learning issues
_____ Sleep Walking
_____ Cancer
_____ von Willebrand Disease

_____ Bowel/Bladder Problems
_____ ADHD
_____ Acquired Immune Deficiency Syndrome
_____ Seizure Disorder

_____ Kidney Disease
_____ Other Chronic Cond.

_____ Other Infectious Diseases:_____

Serious illness or surgeries within the past year: _____

Drug allergy(ies) NO ASPRIN _____

Please provide more specific information about identified health conditions checked, including treatment needed while at Family Hemophilia Camp

Immunizations up to date? Yes _____ No_____

Polio Vaccine:
Measles Vaccine Mumps Vaccine Rubella Vaccine Diphtheria-
Tetanus Tetanus Shot
Varicella (Chicken Pox)
Hepatitis A
Hepatitis B
TB Skin Test
Covid (1)_____(2)_____(booster)_____

BLEEDING DISORDER INFORMATION:
Type of Bleeding Disorder :_____
Severity: _____ Mild _____ Moderate _____Severe
Inhibitor: ____ Yes No
Factor Level: 1 Carrier: ____ Yes _____ No
Treatment Product:
Does child self infuse? ____ Yes ____ No

IS INDIVIDUAL ON PROPHYLAXIS? ____ Yes - No ____
Does individual have a central line? ___ Yes - No ___ If yes, what type?_____
List any orthopedic limitations and/or target joints: _____
Additional comments about infusing individual: _____

IF INDIVIDUAL HAS CENTRAL LINE, PLEASE BRING ALL SUPPLIES AND EQUIPMENT FOR INFUSION WITH CAMPER.

FAMILY MEMBER:

INFUSION INSTRUCTION CONSENT

At camp, your child(ren) will have the opportunity to learn self-infusion instruction on a voluntary, informal, and individual basis by trained medical staff. Your child(ren) could receive this important training when he/she needs factor replacement during camp, but only if the child is voluntarily ready to infuse himself/herself or sibling. This training is also available to children who may not need to infuse for medical necessity.

My signature below indicates my consent for my child(ren) to receive infusion instruction:

Parent/Guardian

MEDICAL RELEASE

(MUST BE SIGNED FOR CAMPERS TO BE ACCEPTED INTO PROGRAM)

In case of medical and/or surgical emergency, I authorize Camp Red Sunrise medical staff to render to myself or other family members (Family Members Full Names):

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Parent/Guardian

Family Member: Name /age_____

Family Member Name/age _____-

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_____ Sleep Walking
_____ Cancer
_____ von Willebrand Disease

_____ Bowel/Bladder Problems
_____ ADHD
_____ Acquired Immune Deficiency Syndrome
_____ Seizure Disorder

_____ Kidney Disease
_____ Other Chronic Cond.

_____ Other Infectious Diseases:_____

Serious illness or surgeries within the past year: _____
Drug allergy(ies) _____
Please provide more specific information about identified health conditions checked, including treatment needed while at Family Hemophilia Camp
Immunization up to date? Yes/No_____
Polio Vaccine:
Measles Vaccine Mumps Vaccine Rubella Vaccine Diphtheria-
Tetanus Shot
Varicella (Chicken Pox)
Hepatitis A
Hepatitis B
TB Skin Test
Covid (1) _____(2)_____(booster)_____
BLEEDING DISORDER INFORMATION:
Type of Bleeding Disorder:_____
Severity: _____ Mild _____ Moderate _____Severe
Inhibitor: Yes/No _____
Treatment Product:
Does the child self-infuse? Yes/No _____
IS THE INDIVIDUAL ON PROPHYLAXIS? Yes/No_____
Does individual have a central line? Yes/No_____If yes, what type?_____
List any orthopedic limitations and/or target joints: _____
Additional comments about infusing individual: _____ IF AN INDIVIDUAL HAS A CENTRAL LINE, PLEASE BRING ALL SUPPLIES AND EQUIPMENT FOR INFUSION WITH A CAMPER.

FAMILY MEMBER:

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Family Member Name/age _____-

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_____ Cancer
_____ von Willebrand Disease

_____ Bowel/Bladder Problems
_____ ADHD
_____ Acquired Immune Deficiency Syndrome
_____ Seizure Disorder

_____ Kidney Disease
_____ Other Chronic Cond.

_____ Other Infectious Diseases:_____

Serious illness or surgeries within the past year: _____

Drug allergy(ies) NO ASPRIN _____

Please provide more specific information about identified health conditions checked, including treatment needed while at Family Hemophilia Camp

Immunization up to date? Yes _____ No_____

Polio Vaccine:
Measles Vaccine Mumps Vaccine Rubella Vaccine Diphtheria-
Tetanus Tetanus Shot
Varicella (Chicken Pox)
Hepatitis A
Hepatitis B
TB Skin Test
Covid (1)_____(2)_____(booster)_____

BLEEDING DISORDER INFORMATION:
Type of Bleeding Disorder :_____
Severity: _____ Mild _____ Moderate X Severe
Inhibitor: ____ Yes No
Factor Level: 1 Carrier: ____ Yes _____ No
Treatment Product:
Does child self infuse? ____ Yes No

IS INDIVIDUAL ON PROPHYLAXIS? ____ Yes No _____
Does individual have a central line? ___ Yes No - If yes, what type?_____
List any orthopedic limitations and/or target joints: _____
Additional comments about infusing individual: _____

IF INDIVIDUAL HAS CENTRAL LINE, PLEASE BRING ALL SUPPLIES AND EQUIPMENT FOR INFUSION WITH CAMPER.

FAMILY MEMBER:

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Family Member Name/age _____-

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_____ Cancer
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_____ ADHD
_____ Acquired Immune Deficiency Syndrome
_____ Seizure Disorder

_____ Kidney Disease
_____ Other Chronic Cond.

_____ Other Infectious Diseases:_____

Serious illness or surgeries within the past year: _____

Drug allergy(ies) NO ASPRIN _____

Please provide more specific information about identified health conditions checked, including treatment needed while at Family Hemophilia Camp

Immunizations up to date? Yes _____ No_____

Polio Vaccine:
Measles Vaccine Mumps Vaccine Rubella Vaccine Diphtheria-
Tetanus Tetanus Shot
Varicella (Chicken Pox)
Hepatitis A
Hepatitis B
TB Skin Test
Covid (1)_____(2)_____(booster)_____

BLEEDING DISORDER INFORMATION:
Type of Bleeding Disorder :_____
Severity: _____ Mild _____ Moderate _____Severe
Inhibitor: ____ Yes No
Factor Level: 1 Carrier: ____ Yes _____ No
Treatment Product:
Does child self infuse? ____ Yes ____ No

IS INDIVIDUAL ON PROPHYLAXIS? ____ Yes - No ____
Does individual have a central line? ___ Yes - No ___ If yes, what type?_____
List any orthopedic limitations and/or target joints: _____
Additional comments about infusing individual: _____

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_____ Other Infectious Diseases:_____

Serious illness or surgeries within the past year: _____
Drug allergy(ies) _____
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BLEEDING DISORDER INFORMATION:
Type of Bleeding Disorder:_____
Severity: _____ Mild _____ Moderate _____Severe
Inhibitor: Yes/No _____
Treatment Product:
Does the child self-infuse? Yes/No _____
IS THE INDIVIDUAL ON PROPHYLAXIS? Yes/No_____
Does individual have a central line? Yes/No_____If yes, what type?_____
List any orthopedic limitations and/or target joints: _____
Additional comments about infusing individual: _____ IF AN INDIVIDUAL HAS A CENTRAL LINE, PLEASE BRING ALL SUPPLIES AND EQUIPMENT FOR INFUSION WITH A CAMPER.

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_____ Other Infectious Diseases:_____

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BLEEDING DISORDER INFORMATION:
Type of Bleeding Disorder:_____
Severity: _____ Mild _____ Moderate _____Severe
Inhibitor: Yes/No _____
Treatment Product:
Does the child self-infuse? Yes/No _____
IS THE INDIVIDUAL ON PROPHYLAXIS? Yes/No_____
Does individual have a central line? Yes/No_____If yes, what type?_____
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Parent/Guardian

Date:

AUTHORIZATION FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATION AT Camp Red Sunrise FAMILY CAMP

For the relief of minor health problems that might temporarily affect your family members comfort while at camp, the nurse maintains a small supply of over-the-counter medications at the site. These medications are dispensed, as needed, under the standing orders of the HTC camp physician.

THE HEALTH HISTORY FORM IS CHECKED FOR ALLERGIES BEFORE ANY MEDICATION IS GIVEN.

If your child(ren) occasionally or rarely use an inhaler or take other asthma medication when needed, please bring the labeled inhaler and/or medicine to camp with the camper in case of need.

IF YOU WANT YOUR FAMILY MEMBER TO RECEIVE OVER-THE-COUNTER MEDICATION, IF NEEDED, AND AT THE DISCRETION OF THE CAMP MEDICAL STAFF, SIGN BELOW.

I authorize Camp Red Sunrise Medical Staff to dispense over-the-counter medication (limited) under the direction of the consulting physician's standing orders, as needed, to my family member while at Camp Red Sunrise Family Camp.

Parent/Guardian_____

Date: _____

I understand to attend this event; all parties will need to show proof of vaccination or a negative Covid-19 test within 72 hours of the event.

Yes I Understand _____

I understand that a $75 check will need to be mailed to NHF, Idaho, to complete my registration. This check will be returned to me when I arrive at Camp Red Sunrise. If I do not attend Camp Red Sunrise, this check will be cashed and used to offset the cost of supplies purchased for my attendance.

Mail Check to:
3989 E 170 N
Rigby, Idaho 83442

Photo & Video/Image Release and Waiver of Liability

I, , give the Idaho Chapter of the National Hemophilia Foundation (NHF Idaho) permission to take my photograph and/or my child's photograph and/or video image. I further agree that the Idaho NHF may use, re-use, publish or re-publish in whole or in part, individually or in conjunction with others, my image or my child's image in any medium and/or for any purpose whatsoever, including but not limited to, illustration, promotion and/or advertising trade.

I further release the Idaho NHF, its Board, its Officers and Representatives from any and all claims of any nature arising from any medium and/or publication. I have read and fully understand the intent and purpose of this release and am signing same without reservation.

I also understand that the NHF Idaho is not responsible for any harm that comes to myself or my child while participating in Camp Red Sunrise family Camp activities and that, should myself or my child be injured, a nurse has been provided for on-site first aid at no cost, but further medical attention will be my responsibility to obtain. I will use my own judgment to determine the safety of each activity and will participate at my own risk.

_____ Date: _____
(Signature of Parent or Guardian)

Names of minor children under this release:
_____
_____
_____
_____