FAMILY MEDICAL FORM

The Family Medical Form consists of pages 3 through 6 of this application. Pages 3 through 7 must be completed for each camper: adults and children. Only one copy is required for page 6 which is a general consent form for the whole family. Page 7 must be completed for individuals who are minors and a parent or legal guardian will not be in attendance at camp.

FAMILY MEMBER:

HEAL TH CARE PROVIDER INFORMATION:

Family Physician Name: Phone No.:
Family Dentist Name: Phone No.:
Specialist Name: Phone No.:

INSURANCE INFORMATION:

Name of Policy Holder:
Insurance Company:
Policy No.:
Group No.:

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:

FAMILY MEMBER:

IMMUNIZATIONS: UP TO-DATE? DATE OF LAST VACCINATION:
[IMMUNIZATION SECTION APPLIES ONLY TO CHILDREN]

Immunization	Up to-date?	Date of last vaccination
Polio Vaccine	Yes _____ No	____________________________
Measles Vaccine	Yes _____ No	____________________________
Mumps Vaccine	Yes _____ No	____________________________
Rubella Vaccine	Yes _____ No	____________________________
Diphtheria-Tetanus	Yes _____ No	____________________________
Tetanus Shot	Yes _____ No	____________________________
Varicella (Chicken Pox)	Yes _____ No	____________________________
Hepatitis A	Yes _____ No	____________________________
Hepatitis B	Yes _____ No	____________________________
TB Skin Test	Yes _____ No	____________________________

Other (Please List): ____

BLEEDING DISORDER INFORMATION:

Type of Bleeding Disorder (A-VII, B-IX, VWD, etc.): _____________________________________
Severity: ______ Mild _____ Moderate X Severe
Inhibitor: Yes No Last Titer and Date: _____________________________________
Factor Level: Carrier: ___ Yes _____ No
Treatment Product: Does child(ren) self infuse? Yes No
Is child(ren) on home infusion? Yes No - If yes, who does infusion? dad or mom
Does camper use EMLA prior to infusing? Yes No Amicar used? Yes No
DDA VP/Stimate Used? Yes No

IS INDIVIDUAL ON PROPHYLAXIS? Yes No
IF YES, PLEASE LIST SPECIFIC DOSING AS WELL AS WEEKLY SCHEDULE:
____

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: ________________________________
In case individual runs out of factor, which pharmacy or home care company does your child use?
____
Contact person at pharmacy: ________________ Phone No.: ______

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 ________________________________ **Date:** _________

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):

or to arrange for myself or my family members to receive any x-ray, anesthetic, medical, dental, surgical procedure, treatment and hospital care which is deemed advisable by and is to be rendered under the supervision of any physician, dentist or surgeon licensed in Idaho. I grant permission for myself or family members to receive treatment for hemophilia and any other medical problems while at camp. In the event of a medical emergency, I grant permission for myself or my family member's to be transferred to a medical facility for treatment at the discretion of the camp medical staff, and I will be responsible for all costs incurred for emergency, in-patient or out-patient care. I understand that I or my family members will be covered solely by the medical insurance policy in which we are enrolled. I authorize a licensed professional to dispense any medication recommended or prescribed by a physician to myself or specific family members.

Parent/Guardian ________________________________ **Date:** _________

Other Comments

AUTHORIZATION FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATION AT HEMOPHILIA FAMILY CAMP

For the relief of minor health problems that might temporarily affect your child(ren)'s 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 HFI camp consulting physicians.

Your personal physician does not need to sign for the medications listed below. Do not send these medications with your child. If needed, our stock supply will be used.

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

Medications stocked at camp are:

- Kaopectate
- Throat/mouth spray (Chloraseptic)
- Soap for poison ivy (Teonu)
- Ipecac
- Decongestants (Sudafed or Actifed)
- Hydrogen peroxide (Alcohol, Camphophenique)
- Cream for athlete's foot or ringworm (Lotrimin)
- *Epinephrine
- Cough syrup (Robitussin-DM)
- Cream for itching (Hydrocortisone)
- Glucose for diabetic emergency
- Throat lozenges (Cepacol)
- Antibiotic cream or ointment
- Blistex
- Non-aspirin pain/fever relievers such as Tylenol
- Lotion/cream for chapped skin (Eucerin)
- Maalox, Milk-Magnesia
- Antihistamines (Benadryl, Chlortrimeton)
- Skin pain (Betadine, Mercurochrome)
- Burns/sunburn (Rhutigel or Aloe Vera)
- Silvadene (for burns)

*Epinephrine is a prescription medication that is kept on site for use in the event of a life-threatening allergic reaction.

**'NOTE: Brand names have been listed, but their generic equivalent or the same medication of a different brand name may be substituted.

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 CHILD(REN) TO RECEIVE OVER-THE-COUNTER MEDICATION, IF NEEDED, AND AT THE DISCRETION OF THE CAMP MEDICAL STAFF, SIGN BELOW. IF THIS LIST CONTAINS MEDICATION YOU DO NOT WANT YOUR CHILD(REN) TO RECEIVE, DRAW A LINE THROUGH THAT MEDICATION BEFORE SIGNING.

I authorize the Hemophilia Camp Medical Staff to dispense over-the-counter medication (limited to those on list) under the direction of the consulting physician's standing orders, as needed, to my child(ren) while at Hemophilia Family Camp.

Parent/Guardian ______________________________________ Date: __________

Other Comments

FAMILY MEMBER:

INSTRUCTIONS FOR MEDICATION AT FAMIL HEMOPHILIA CAMP

IF ROUTINE MEDICATION WILL BE NEEDED AT HEMOPHILIA CAMP, THE FOLLOWING MUST BE COMPLETED:

1. Parent consent must be in writing.
2. Prescription medication must be in its original container with a clear and accurate pharmacy label which can be accepted as physician instructions. "Take as directed" or "as needed" is NOT specific and cannot be accepted as direction.
3. If the directions on the bottle are different from what the physician is currently prescribing, written instruction is required from the physician.
4. Non-prescription over-the-counter medication that your child's physician has recommended must be in its original labeled container sent with instructions, written and signed by the physician and signed parent consent. Please send over-the-counter medications only if absolutely necessary and if that medication is not listed on the Hemophilia Camp list of over-the-counter medications.
5. Place all medication required at the site into a zip-lock bag labeled with your child's name. Carry the medication bag separately and give it directly to the nurse. If the medication has been packed away, you will need to find it and give it to the nurse upon arrival at camp.
   EXCEPTIONS: Campers requiring inhalers or insect sting kits may keep those items with them, however, this consent form must be signed, and the medication must be shown to the nurse upon arrival to camp.
6. At the end of Family Hemophilia Camp, the site nurse will return any left-over medication to you. If you, or another adult assigned by you, do not pick up the medication when you pick up your child, it will be secured at the Hemophilia Treatment Center for you to pick up at a later time.

Parent/Guardian authorization for Hemophilia Camp nurse to administer medication - I am requesting that my child(ren), ________________________________, be given or be assisted in taking the following:
____

Parent/Guardian ____________________________________ Date: __________________

Other Comments