

**CONFIDENTIAL INFORMATION**  
**CAMP OPEN ARMS 2009**  
**CAMPER APPLICATION**  
**July 6<sup>th</sup> -17<sup>th</sup>**  
**Ages 3 to 14 YEARS**

**THIS FORM MUST BE COMPLETELY  
FILLED OUT BEFORE THE CAMPER  
CAN BE ADMITTED TO CAMP**

**Please Print (Pen Only) or Type**

1. Camper's Name \_\_\_\_\_ Sex: Male Female  
D.O.B: \_\_\_/\_\_\_/\_\_\_ Age at time of camp \_\_\_\_\_ **Shirt Size** \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone( ) \_\_\_\_\_

2. Father's Name \_\_\_\_\_  
Home Phone( ) \_\_\_\_\_ Work Phone( ) \_\_\_\_\_  
Mother's Name \_\_\_\_\_  
Home Phone( ) \_\_\_\_\_ Work Phone( ) \_\_\_\_\_  
Guardian's Name \_\_\_\_\_ Phone( ) \_\_\_\_\_

3. Person to call in case of emergency if parent/guardian cannot be reached:  
Name: \_\_\_\_\_ Phone( ) \_\_\_\_\_  
Relationship to child: \_\_\_\_\_

4. Name of pediatrician: \_\_\_\_\_ Phone( ) \_\_\_\_\_  
Name of dentist/orthodontist: \_\_\_\_\_ Phone( ) \_\_\_\_\_

5. Do you carry family medical/hospital insurance?  
If so, indicate carrier: \_\_\_\_\_ Policy or Group #: \_\_\_\_\_

**6. Health History to be completed by parent/guardian.**

Cancer (Type & Date of diagnosis): \_\_\_\_\_

Sickle Cell Anemia trait or disease: \_\_\_\_\_

Other Blood related disease: \_\_\_\_\_

If the above three do not apply to you, please briefly explain your connection to Camp Open Arms:

Vision Problems Yes No Explain: \_\_\_\_\_

Hearing Problems Yes No Explain: \_\_\_\_\_

Asthma Yes No Explain: \_\_\_\_\_

Diabetes Yes No Explain: \_\_\_\_\_

Seizures Yes No Explain: \_\_\_\_\_

Learning Disabilities Yes No Explain: \_\_\_\_\_

Emotional/Behavioral Issues Yes No Explain: \_\_\_\_\_

Allergies (Food, Medication, or Insects) Yes No If yes, does the allergy require medication?

Explain: \_\_\_\_\_

If Epi-pen is needed, please send with child the first day of Camp, otherwise the child will not be allowed to return to Camp until Epi-pen is received.

Other Medical concerns: \_\_\_\_\_

**7. Physical restrictions or limitations to:**

Strenuous activities? Yes No Explain: \_\_\_\_\_

Swimming/diving? Yes No Explain: \_\_\_\_\_

Exposure to sunlight? Yes No Explain: \_\_\_\_\_

Exposure to hot/cold temperatures? Yes No Explain: \_\_\_\_\_

Are there any activities your child will not be able to do because of limitations ex. swimming? Yes No Explain: \_\_\_\_\_

**8. Is your child *currently* receiving Chemotherapy or Radiation? Yes No**

Explain: \_\_\_\_\_

- 9. Does your child *currently* have:**
- 1. Low White Count Yes No
  - 2. Low Hematocrit Yes No
  - 3. Low Platelets Yes No

**10. \*Please list all prescription and over-the-counter medications your child is taking daily:**

Drug	Dosage	Time of Administration	To be administered at camp?		Comments
			(Please Circle) Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	

(Please attach additional paper if necessary)

**\*If you are bringing a prescription to camp, please give the medication to the medical director the first day at camp. Medications must be in a properly labeled bottle with the name of the child, name of the medication, dosage, and the time of administration clearly marked.**

**We do encourage you to keep your child on any medications taken regularly during the school year to help him/her focus (i.e. Ritalin, Adderall, etc.)**

**Any over-the-counter medications available at camp (Tylenol, Advil/Motrin, Benadryl, etc.) will be administered at the discretion of the medical staff.**

**11. Parent Authorization:** This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me and the examining physician. I hereby give permission to the physician selected by the camp health director in the event I cannot be reached in an emergency to order X-rays, routine tests, hospitalize, secure proper treatment, and to order injections and/or anesthesia and/or surgery for my child as named above. I also give permission to administer over-the-counter medications to my child at the discretion of the medical staff.

Signature \_\_\_\_\_ Witness \_\_\_\_\_

**--\$100 per camper (Scholarships are available by application.)**

**PLEASE DOUBLE CHECK BEFORE MAILING:**

- Completed camper application is enclosed.
- Medical form completed by healthcare professional is enclosed.
- Complete and signed release forms are enclosed.
- Signed camper rules are enclosed.
- Check or money order is enclosed.

**Please return to:**  
 Mary Casselman  
 C/O Camp Open Arms  
 Gilda's Club/Cancer Action  
 255 Alexander Street  
 Rochester, NY 14607

**Call (585) 423-9700 with questions.**

**PHYSICAL EXAMINATION (TO BE COMPLETED BY HEALTHCARE PROFESSIONAL)**  
**CAMP OPEN ARMS 2009**  
**EXAM MUST BE WITHIN ONE YEAR OF LAST PHYSICAL**  
**PLEASE RETURN BY MAY 15<sup>TH</sup>**

**Please return to:**  
 Mary Casselman  
 C/O Camp Open Arms  
 Gilda's Club/Cancer  
 Action, Inc.  
 255 Alexander Street  
 Rochester, NY 14607  
 FAX: (585) 423-9072

Camper Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Date of Exam: \_\_\_\_\_

General Health/Development: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Skin \_\_\_\_\_  
 HEENT \_\_\_\_\_ Lungs \_\_\_\_\_ Heart \_\_\_\_\_ Abdomen \_\_\_\_\_  
 GU \_\_\_\_\_ Musculoskeletal \_\_\_\_\_ Neurologic \_\_\_\_\_

Use this area to describe fully any additional positive findings:  
 \_\_\_\_\_  
 \_\_\_\_\_

I hereby supply evidence that these mandatory immunizations were completed on the following dates: (if child had a disease, include dates.)

- 1) DTaP \_\_\_\_\_
- 2) Polio \_\_\_\_\_
- 3) Hib \_\_\_\_\_
- 4) Prevnar \_\_\_\_\_
- 5) Hep B \_\_\_\_\_
- 6) MMR \_\_\_\_\_
- 7) Varivax \_\_\_\_\_
- 8) Tetanus Booster \_\_\_\_\_
- 9) Other \_\_\_\_\_

Please indicate any significant medical conditions, concerns, or restrictions that would effect the participation in any camp activities: (i.e. strenuous activities, hot/cold temperatures, swimming, etc.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If the camper has sickle cell anemia, is the child able to participate in indoor/outdoor water activities? Yes No  
 If yes, is there any restriction on water or air temperature during these activities? \_\_\_\_\_

Provider Name \_\_\_\_\_ Phone # \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_