South Florida's Camp for Kids with Arthritis
AD Barnes Leisure Access Center
3401 SW 72nd Avenue, Miami, Fl

June 21, 2015 – June 27, 2015

Ages 8-12

CAMPER APPLICATION

Application Directions:

- ✓ Please fill out completely as incomplete applications can NOT be accepted.
- ✓ Application deadline is May 1, 2015. Priority will be given to newly diagnosed children and those who have not attended Camp FunRise before.
- ✓ Campers and their families will be notified May 19, 2015.
- ✓ Campers not accepted will be placed on a waiting list.
- ✓ If your child is unable to attend, PLEASE contact us immediately, so that another child may be given that opportunity – Thank you!

If you have any questions, please contact:
Susan Cuellar 800-850-9455; scuellar@arthritis.org

Applications are to be mailed to:
Rafael F. Rivas-Chacon, M.D.
Attention: Camp FunRise
P.O. Box 431169
South Miami, FL 33243-1169

Sponsored by:

CAMPER APPLICATION

To be completed by parent or guardian. Please print or type. All information in this form will be used for staff use only and will be held in strict confidence.

1. PERSONAL INFORMATION

Applicant's Name_____
Last First Middle

Birth Date_____ Age_____ Sex □ Male □ Female

Diagnosis of Health Problem_____Height_____Weight_____

Age at Diagnosis of Health Problem_____

Parents' (or Guardians') Names_____

Who is authorized to pick up child, if not parents:_____

Address (Street)_____

City_____County_____State_____Zip_____

Father's Occupation_____Title_____

Employer_____ Father's email _____

Home Telephone ( ) _____ Work Telephone ( ) _____ Ext. _____

Cell Telephone ( ) _____

Mother's Occupation_____ Title_____

Employer_____ Mother's email _____

Home Telephone ( ) _____ Work Telephone ( ) _____ Ext. _____

Cell Telephone ( ) _____ T-shirt Size: youth ( )M ( )L ( )XL ; adult ( )S ( )M ( )L ( )XL

2. GENERAL FAMILY INFORMATION

The following information is necessary in order to assure a successful camp experience and the best possible care for your child. Please answer each question providing us with as much detail as possible.

How many children are in your family? _____

Ages and sex of children: Male(s) _____

Female(s) _____

With whom does the applicant live—what family members? (check those which apply)

□ Father □ Brother(s) □ Guardians

□ Mother □ Sister(s) □ Other_____

□ Step Father □ Grandmother please indicate

□ Step Mother □ Grandfather

Do any other members of the family have a chronic health problem? □ Yes □ No

If Yes, please indicate (check those which apply)

□ Brother(s) □ Sister(s) □ Other_____

□ Father □ Mother please specify

Type of Health Impairment_____

Have there been any significant changes in your child's home life over the past year or since he/she last attended camp (i.e. moving, change in family structure, etc)? □ Yes □ No

If yes, please explain_____

(*continued on other side)*

3. EDUCATION INFORMATION

How is your child adjusting to school this year? □ With difficulty □ Average □ Very well

Please explain: _____

_____

Is your child in the grade that he/she should be for his/her age? □ Yes □ No

Is your child in a special education class? □ Yes □ No If so, what for?

□ Learning disability? □ Yes □ No

□ Mental retardation - is it □ Mild □ Moderate □ Severe?

□ Behavioral problem? □ Yes □ No

□ Emotional problem? □ Yes □ No

Is your child in a combination of regular and special education classes? □ Yes □ No

If so, please explain: _____

_____

_____

Has your child ever received physical or occupational therapy services? (check those which apply)

□ Yes □ No □ Currently □ In the past

If Yes, please supply us with:

Therapist Name_____

Address_____

Telephone ( ) _____
Area Code

Has your child ever received counseling services? (check those which apply)

□ Yes □ No □ Currently □ In the past

If Yes, please supply us with:

Therapist's/Counselor's Name_____

Address_____

Telephone ( ) _____
Area Code

4. RELATIONSHIPS WITH OTHERS

Does your child tend to have difficulty with relationships … (check those which apply)

At Home?	At School?	In New Environments?
□ Rarely	□ Rarely	□ Rarely
□ Sometimes	□ Sometimes	□ Rarely
□ Often	□ Often	□ Often

Has your child experienced any upsetting or traumatic events? □ Yes □ No

□ Within the past 6 months □ Within the past 1 or 2 years □ Other_____

If Yes, please explain_____

5. MEDICAL FORM

THESE FORMS ARE REQUIRED FOR CAMP ATTENDANCE! NO CHILD MAY ATTEND CAMP WITHOUT A CORRECTLY COMPLETED HEALTH EXAMINATION FORM! This side to be filled out by the camper's PARENT or adult camper. It should be checked by your physician. Answer all questions. Use additional paper if needed. Please fill out both sides of this application.

Camper Name_____ Birth Date_____Sex_____Age_____

Address_____ City_____State_____Zip_____

Parent(s) _____Phone ( ) _____

In an emergency, notify: _____Phone ( ) _____

Health History: Check and give dates if camper has ever had any of the following problems.

_____ seizure	_____ T.B.	_____ diabetes	_____ hepatitis A	_____penicillin allergy
_____ retardation	_____ lung problems	_____ gastritis	_____ hepatitis B	_____drug allergy
_____ ear infection	_____ hypertension	_____ ulcers	_____ bleeding problems	_____ insect bite allergy
_____ asthma	_____ heart problems	_____ GI problems	_____ chicken pox	_____ other allergy

Explain answers checked above_____

_____

Type of Rheumatic Disease/Arthritis_____

Other Medical Problems_____

_____

Operations and Serious Injuries (dates) _____

Family Doctor/Pediatrician_____Phone ( ) _____

Rheumatologist_____ Phone ( ) _____

Health Insurance Carrier/Program_____Policy #_____

Medicare/Medical #_____

Has your child been in good health for the past 4 weeks? □ Yes □ No

If No, please explain: _____

Has your child been exposed to a contagious disease? □ Yes □ No

If Yes, what disease and when? _____

Date of child's most recent tetanus booster shot_____ Are child's immunizations up to date? □ Yes □ No

If No, please explain: _____

Describe any special diet: _____

_____

Describe special procedures to do or any suggestions you have: _____

_____

Can your child participate without restriction in a camp program designed for children with arthritis? □ Yes □ No

If No, explain: _____

Activities to Restrict: _____

Parents 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 director to order x-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, and/or anesthesia and/or surgery for my child as named above.

Signature_____ Witness_____

Relation to camper_____ Date_____

6. YOUR CHILD

Getting to know your child before he/she attends camp helps insure that your child gets the most out of the camp experience.
We appreciate your time and care in completing this form. The confidentiality of your answers will be respected.
PLEASE COMPLETE BOTH SIDES OF FORM.

Child's Name_____ Date of Birth_____

Nickname if preferred_____ Phone ( ) _____

Address_____ City_____State_____ Zip_____

Child lives with:

Name_____ Relation_____ Day Phone ( ) _____

Name_____ Relation_____ Day Phone ( ) _____

Names and ages of:

Brothers_____

Sisters_____

Has your child been to camp before? _____ Where and how long? _____

_____

How does your child feel about going to camp? _____

_____

What do you hope your child will gain from the camp experience? _____

_____

What are your child's interests/hobbies? _____

_____

What does you child do with his/her spare time? _____

_____

Estimate your child's swimming ability: _____ Excellent _____ Average _____ Poor _____ Can't Swim

What are your child's sleep habits? _____ Light _____ Heavy _____ Sleepwalks

_____ Bed wetter _____ Snores _____ Falls out of bed

What duties/responsibilities does your child have around your home? _____

_____

Please provide other information that you feel is important for us to know: _____

_____

_____

Parent's Name_____ Date: _____

7. AN IMPORTANT NOTE ABOUT MEDICATIONS

Camp FunRise is seven days long. Please send enough medicine for at least nine days or longer. This will provide extra medicine in case some pills are dropped. Remember to include "PRN" or as "needed" medicines such as antacids, if your child uses them.

All medicines must be sent to camp in their original pharmacy containers. This includes prescription medications such as antibiotics and "over the counter" medicines such as vitamins and antacids. Do not mix different medicines in the same container. Do not send medicine in weekly dispensing pill boxes.

If you do not have the original medicine container, put each medication in a separate container or plastic bag. Have your doctor or pharmacist write a note which describes and identifies each medication and indicates how each medication is taken. The note should be signed by the doctor or pharmacist.

In order to protect your child's health, we cannot give your child unlabeled, unidentified medications. It is impossible to identify a medication by its color, size and shape. Different companies produce different looking pills of the same medication and many different medications look the same.

When you take your child to the camp bus, or upon arrival, if you are driving your child to camp, we will collect all medications. They will be kept safely in the infirmary and will be dispensed to the campers at the appropriate times by a doctor and a nurse practitioner.

We will review your child's medication schedule with you and your child at the bus or camp. Please do not leave until we have reviewed this information with you. We realize that medication schedules change and we want to make sure we have the most recent information. It will help if you bring a written medication schedule with you to camp. Use the back of this form to fill out just before camp.

PHYSICIAN PERMISSION FORM

_____ is scheduled to attend CAMP FUNRISE, a week long residential camp for children with
(Child's Name)
arthritis. CAMP FUNRISE is located in South Miami, Florida and is in close proximity to Miami Children's Hospital. There will be a pediatric rheumatologist available 24 hours a day as well as registered nurses on duty at all times. All activities will be closely supervised by the medical staff and a daily program of exercise and aquacize will be administered by licensed physical and occupational therapists. By acknowledging this form we request that the above named child be medically cleared for the purposes of camp activities. Please sign below if the patient has your permission to attend and please note any restrictions or concerns. **For further information**: Rafael Rivas-Chacon, MD, (305) 663-8505.

_____ _____

MD Signature Please Print Name

Address: _____

Telephone: _____ Date: _____

After Hours Telephone: _____

8. MEDICATION

Child's Name: _____

Name of Medicine	Dose in Milligrams	Times to be taken

Any specific instructions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

MEDICAL CONSENT FORM

I hereby give permission to the physicians and nurses designated by the Medical Director of Camp FunRise, the camp for children with Arthritis, to treat my child at camp.

Every effort will be made by the camp director to contact parents, legal guardians and attending physician of the child as soon as an emergency arises.

_____ _____

Signature of Parent/Guardian Date

PHOTO CONSENT FORM

I hereby authorize the use and reproduction by Camp FunRise and the Arthritis Foundation of all photographs and video taken of my child while attending camp, and taken of myself during the opening day BBQ.

_____ _____

Signature of Parent/Guardian Date

Please return application to:

Rafael F. Rivas-Chacon, M.D.
Attention: Camp FunRise
P.O. Box 431169
South Miami, FL 33243-1169

****Incomplete applications can NOT be accepted ****
PLEASE – review your application and make sure it is filled out correctly.

For more information, contact Susan Cuellar at 800-850-9455; scuellar@arthritis.org
Thank you!

CAMP FUNRISE
A CAMP FOR CHILDREN WITH JUVENILE ARTHRITIS

In consideration of receiving acceptance from Camp FunRise to participate in their programs, receive instruction from qualified staff and use their equipment and facilities. I hereby understand and agree to this WAIVER OF LEGAL RIGHTS AND ASSUMPTION OF RISK and to the terms hereof as follows.

(1) That there may be hazards associated with specific activities and activities sites which include but are not limited to: accidents while traveling around the grounds or to and from an activity site, bodily injury or illness or property damage, exposure to temperature extremes, inclement weather and all manner of natural hazards. I understand that as a result of these dangers and other hazards, there is a potential for injury or even fatal injury to myself or other participants. Nonetheless, I VOLUNTARILY DESIRE TO PARTICIPATE IN SUCH ACTIVITIES BEING FULLY AWARE OF THE DANGER AND VOLUNTARILY ASSUME ALL RISK OF LOSS, DAMAGE OR INJURY.
Initials of parent or legal guardian on behalf of child _____

(2) That I further WAIVE AND RELEASE any and all legal rights that may accrue to me as a result of personal injury, property damage or other damage that I may suffer while involved in CAMP FUNRISE programs. This release is intended to discharge in advance CAMP FUNRISE, its agents, employees, officers, directors, and assigns from all claims brought by or on behalf of myself, my hairs or assigns.
Initials of parent or legal guardian on behalf of child _____

(3) That I agree to act in a reasonable and safe manner while a participant in any CAMP FUNRISE program so as not to endanger myself or the lives of other persons or their property and agree to indemnify CAMP FUNRISE for my failure to act in such reasonable manner.
Initials of parent or legal guardian on behalf of child _____

(4) That I further acknowledge that there are no warranties applicable to the equipment provided by CAMP FUNRISE whether expressed or implied. THERE IS NO WARRANTY OR MECHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE and I am accepting all equipment AS IS after having examined the same.
Initials of parent or legal guardian on behalf of child _____

(5) That in the event hat I cannot be reached in an emergency I hereby grant permission to the CAMP FUNRISE Medical Director, Director or Course Director to obtain emergency medical treatment, to hospitalize and secure proper treatment which may be deemed necessary for the participants well being.
Initials of parent or legal guardian on behalf of child _____

(6) That I have received adequate information and satisfactory explanation of any unfamiliar terms regarding the rules, regulations, policies and instructional procedures governing the operation of CAMP FUNRISE and have been provided with the opportunity to ask questions to clarify any information which may be unfamiliar to me.
Initials of parent or legal guardian on behalf of child _____

(7) That as a parent or legal guardian of the participant, I have read the above release, affixed my initials thereto, and fully understands its contents. In consideration of allowing my son, daughter, or legal ward to participate in CAMP FUNRISE programs, I agree to indemnify and hold harmless CAMP FUNRISE, its agents, employees, officers, directors and assigns against loss from any and all claims, demands or actions made by such minor or by anyone on behalf of such minor including derivative claims for loss of service.
Initials of parent or legal guardian on behalf of child _____

Signature of parent or legal guardian: _____ Print Name: _____

This is the _____ day of _____, 20_____.

CONSENT FOR PHOTOGRAPHY, TELEVISION AND SOUND RECORDS FOR MEDICAL PURPOSES

In the interest of medical science I authorize Miami Children's Hospital, its physicians, authorized technicians and employees to take still and video photograph as well as sound recordings of me/my child at their discretion during the courses of diagnosis and/or treatment, including any operative or special procedures performed.

I understand that:
The taking of this material will be done with the consent of my attending physician and under the conditions and times approved by him or her. The material will be used for the purpose of medical education, study and research including use of the same in scientific or professional publications and that the name of the patient, his or her parents shall not be used to identify such material.

I further understand that this consent shall act to expressly release from liability the above hospital, members of the medical staff, house and nursing staff, members and officers of its Board of Trustees, its agents, servants and employees and such release shall include any ill effects which may result from the use of the above material. I shall not receive compensation or other gifts/payments for the taking and/use of such materials.

Patient Name: _____

Parent or legal guardian: _____Date: _____

Signature _____

Please print your name: _____Day Time Phone: _____

Address: _____

City:_____ State_____: Zipcode:_____
Event/Story

CONSENT FOR PHOTOGRAPHY, TELEVISION, SOUND RECORDING AND INTERVIEWS REGARDING MARKETING AND PUBLIC RELATIONS PROJECTS

I hereby give my consent for my child and/or myself to appear in photography, videos, publications and/or interviews for news agencies and/or as a contribution to the efforts of the marketing departments of Miami Children's Hospital & Miami Children's Hospital Foundation.
I understand that such product or interview could be used in hospital publications, radio, television, newspaper, magazines, or advertising.
I understand that in giving this approval that it is valid in perpetuity unless I submit a written letter to the Marketing Department discontinuing the undersigned.
I understand that such product or interview could be used in hospital publications, radio, television, newspaper or magazines.
I do , do not authorize the disclosure of my child's identify or mine for such photographs and/or interviews.
I shall receive no compensation or other gifts/payments for any of the above.

Patient Name: _____

Parent or legal guardian: _____Date: _____

Signature _____

Please print your name: _____Day Time Phone: _____

Address: _____

City:_____ State_____: Zipcode:_____

Event/Story