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

June 19, 2016 – June 25, 2016

Ages 8-12

CAMPER APPLICATION

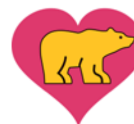
Application Directions:

- ✓ Please fill out completely as incomplete applications can NOT be accepted.
- ✓ Application deadline is May 6, 2016. 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 27, 2016.
- ✓ 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:
Candy Gonzalez 800-850-9455, cgonzalez@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:



Nicklaus Children's Hospital

abbvie

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______________________

please indicate

☐ Step Father ☐ Grandmother

☐ 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______________________

please specify

☐ Father ☐ Mother

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 Nicklaus 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 aquasize 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 Candy Gonzalez at 800-850-9455; cgonzalez@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 ______________: Zip Code: ______________________
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

Medical Education Marketing/Public Relations MIAMI CHILDREN'S HOSPITAL, MIAMI, FL 33155
Consent Form FORM # 798.043.585 (MKTG58)