CAMP JAM 2015

CAMPER MEDICATION INFORMATION

PLEASE READ BEFORE FILLING OUT MEDICATION FORM ON NEXT PAGE

Medication Form Instructions:

1) Please note that camp is 4 days long. Please send enough medication for 5 days. This will provide extra medicine in case some pills are dropped or lost. Remember to include any "as needed" medications including over the counter medications such as antacids if your child uses them.

2) **All medicines must be sent to camp in their original pharmacy containers with current dosing information**. In order to protect your child, we cannot give your child unlabeled, unidentified medications. **Please make sure all bottles are labeled with the camper's name!**

3) **Note: Please bring a small box or plastic container to hold your child's medication.**
(Please label the box with their name)

4) When you bring your child to camp check in, we will collect the medications and you will have an opportunity to speak with the camp nurse. Medications will be kept by the camp nurse in Camp JAM's very own nurses' station and dispensed at appropriate times by the nurse. We will review your child's medication schedule at camp check-in.

5) If any medication changes occur between the time of submission of this form and the date camp begins, a written notification by your physician of the changes must be provided to Jazzmin to update your camper's form. *(If the changes occur very close to camp please provide the notification to the camp nurse at check-in.)*

****Note to parents: Please make sure that your forms are filled out entirely. Originals will be the only accepted documentation. Your child's forms must be received in the Arthritis Foundation office no later than June 1, 2015. No exceptions.**

Personal Medical History

It is important for the Camp JAM Medical Staff to know the health condition of the camper before Camp. We appreciate your time and care in completing this form. The confidentiality of your answers will be respected. **Please complete all sections clearly.**

CAMPER'S NAME_____

DATE OF BIRTH_____

Physician Contact Information

RHEUMATOLOGIST'S NAME_____

PHONE #(_____)_____

RHEUMATOLOGY OFFICE ADDRESS _____

RHEUMATOLOGY NURSE'S NAME_____

FAMILY PHYSICIAN'S NAME_____

PHONE #(_____)_____

Health Insurance

Insurance Coverage for camper accidents or illnesses while participating in programs at Camp Joint Adventures is the responsibility of the camper's family. Please include a copy (front and back) of any health insurance card(s) that you would like used in case of emergency.

HEALTH INSURANCE CARRIER_____

POLICY #_____ID#_____

NAME OF INSURED_____

HEALTH INSURANCE CARRIER TELEPHONE # _____

Immunizations

Are immunizations up to date? YES_____NO_____

DATE OF LAST TETANUS BOOSTER:_____

Please contact your child's doctor's office to get this information.

Health History

This section MUST be completed, even if your child is a RETURN camper

What is your child's rheumatic (arthritis) diagnosis or diagnoses?

_____

_____

At what age or year was he/she diagnosed?_____Date of last flare-up?_____

What particular areas are involved in typical flare-ups?_____

_____

What complications, if any, has your child experienced?_____

_____

Does your child have activity restrictions? If so, please describe – this could include walking, sitting on the floor, etc._____

_____

_____

_____

Other Medical History Information

Please check any of the following illnesses if ever experienced by your child: if yes, then report the last date your child was treated for the problem and discuss in the space provided.

Seizure_____ ***TB***_____ ***Diabetes***_____
Gastritis_____ ***Migraines***_____ ***Thyroid problems***_____
Ulcers_____ ***Hepatitis***_____ ***Hypertension***_____
Chicken pox_____ ***Asthma***_____ ***Other lung problems***_____
Bleeding problems_____ ***Heart problems***_____ ***Behavior problems***_____
Psychiatric illness (must define below)_____ ***ADHD***_____
Depression_____ ___ **None – if "none" please check this box**
Other_____
Explanations:_____

_____

If there is a behavior/psychiatric illness, how is it managed? Do you have tips on how to handle this at camp?:_____

_____

Diet

Please describe any special diet or dietary restrictions:_____

_____

_____

_____

___ **No Diet Restrictions – if "none" please check this box**

Allergies

Is your child allergic to *anything* (foods, insects, medication, etc)? YES NO (circle one)
If you answered YES please complete below. If you answered NO please skip to the "Medications" section, p. 12.

We want to ensure that your child has a wonderful, safe experience at Camp Joint Adventures.

1. **Medication Allergy**
   a. What medication(s) is your child allergic to?

   b. What was the reaction(s) to the medication(s)?

   c. When was the last time such a reaction happened? Date/Year

   d. How did you handle the reaction?
      i. Just stopped the medication and did not give again
      ii. Antihistamine or steroids? List _____
      iii. See the doctor?
      iv. Go to the ER? (date/year)

2. **Environmental Allergy**
   a. What is your child's environmental allergy to? (Please circle all that apply)

      Pets Mold Dust

      Pollen Bee/Wasp/Hornet Other: _____

   b. What was the reaction(s) to this substance(s)?

   c. When was the last time such a reaction happened? (Date/Year)

   d. How do you handle this allergy with the school?

e. How did you handle this reaction?
    i. Antihistamine or steroids? List _____
    ii. Epi-pen?
    iii. See the doctor?
    iv. Go to the ER? (date/year)

3. Food Allergy

a. What is your child's food allergy to?

b. What was the reaction(s) to this food(s)?

c. When was the last time such a reaction happened? (date/year)

d. How do you handle this allergy with the school?

e. How did you handle this reaction?
    i. Antihistamine or steroids? List _____
    ii. Epi-pen?
    iii. See the doctor?
    iv. Go to the ER? (date/year)

4. Do you have any other concerns or questions about your child's allergy at Camp JRA?

Please use the form below for any other allergies if needed

Allergic to what?	Medication, Environment or Food?	What was the reaction?	When was the last time the reaction happened?	If applicable, how do you handle this allergy at school?	How do you handle the reaction (medications used, restrictions, etc)?

Medications

This section MUST be completed, even if your child is a RETURN camper

Please list all your child's **medications and vitamins**, including **commonly used over-the-counter medications**. Please be exact with doses, times given and ways the medicine is given. (See example)

EXAMPLE OF MEDICATION LIST

MEDICATION/ VITAMIN (name/dose in mg or ml (cc)-See bottle label)	HOW MANY TIMES GIVEN AND HOW	WHEN (Day & Time)
Methotrexate 25mg/ml	*0.5 ml by sq shot*	*Friday 7 PM after dinner*
Naprosyn 250 mg tabs	*1.5 tabs by mouth*	*8 AM and 7 PM after meal*
Albuterol Inhaler	*2 puffs inhaled*	*4x a day before exercise*
Tylenol 500 mg tabs	*1 or 2 tabs by mouth*	*4x a day as needed for headaches*

Camper's Medication List			
MEDICATION Name; Dose in mg or ml (cc)	HOW MANY ARE GIVEN AND HOW (by mouth, IM or SQ)	WHEN Day, Time	SPECIAL PROCEDURE

The table above should MATCH the medication list given by your child's Rheumatologist, as well as the medications your child brings to Camp Joint Adventures. Let us know PRIOR TO CAMP if the medications have changed

This section MUST be completed, even if your child is a RETURN camper

We may need to give an over-the-counter medication that you have not sent along to Camp. Please review the following list of medicines and mark yes if we have permission to give it to your child.

Over-the-Counter Medication	Yes	No
Acetaminophen (for pain, headaches, fever)		
Calamine (for itching, bug bites)		
Benadryl Cream or Spray (for itching, bug bites)		
Benadryl elixir or tablets (for allergic reactions)		
Sunscreen		
Eye Wash (for itching, irritation, redness)		
Tums or antacids		
Ibuprofen		
Aloe Vera		
Hydrocortisone Cream		
Antibiotic ointment		

PARENT OR GUARDIAN MEDICAL AUTHORIZATION

The information supplied on each of the forms provided to the Arthritis Foundation, Heartland Region, Camp JAM is correct to the best of my knowledge, and my by my signature I give permission for the Camper identified below to participate and engage in all prescribed camping activities, except those noted by the examining physician and myself. In the event a medical issues arises, my child will be directed to the onsite medical staff person, who will contact me to discuss next steps.

Camper's Full Name:_____

Signature of Parent or Guardian:_____

Parent or Guardian Printed Name:_____

Date:_____

A witness signature is required.

Witness Name:_____ Witness Signature:_____

Date:_____

Authorization to Consent to Hospital Medical Treatment for Minor Child

I, (we) _____ and _____of _____
name *name* *city*

_____County, _____, do hereby state that I am (we are)
county *state*

the natural parent(s) or legal guardian(s) having legal custody of
_____, a minor, age_____ , born ____/____/_____
child's first & last name

who resides with me (us) at _____
address

I (we) authorize the physicians of the Emergency Department along with appointed consultants to perform all diagnostic studies including the administration of anesthesia, blood transfusions, all medical and/or dental treatment including immunization against disease and emergency surgical intervention which might be deemed necessary or advisable for the best interest of the Camper.

Dated this _____ day of _____, 20_____

Allergies_____ Religion_____

Signed 1 _____ Signed 2 _____

Witness_____

Effective Date:_____ Expiration Date: 6/30/2015

PHYSICIAN CONSENT FORM

Camper's Name:

The above named child is scheduled to attend the Gertrude and Harry G. Fins Camp J.A.M. - Juvenile Arthritis and Me, a four-day retreat for children with any form of arthritis or related rheumatic condition. The event will be held on June 25th-28th at Covenant Harbor in Lake Geneva, WI. A physician and two nurses will be at the campsite for the program to dispense medications and monitor the safety and health of participants. Camp activities will include:

outdoor nature education
arts and crafts
bingo
dancing
*tower climb
* swimming
archery, air rifle
campfire
* nature hike
games
* orienteering
* zip line
* canoeing
* ropes course

The retreat program is designed for children with mild to moderate disease involvement. Several of the above activities are highlighted with an asterisk (*). These activities will create a certain amount of stress on the child's joints and muscles. It is up to the parent and physician to determine the appropriateness of these activities for the individual child. Children with severe joint involvement should attend JA camps sponsored by either the Wisconsin or Indiana Arthritis Foundation chapters, as these camps are hosted at facilities designed to meet such special needs.

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 consent to participate in Camp J.A.M. 2015. Please note any restrictions or limitations the child should follow.

Restrictions/limitations, if any:

Physician's Signature

(_____)_____
Area code and phone number

Physician's Name - Please Print