The Arthritis Foundation's Juvenile Arthritis Warriors Camp 2016

Bradford Woods Martinsville, IN July 6th-July 8th

Participant Application

First Name_____ Nick name_____Last Name

_____

Gender _____Date of Birth (MM/DD/YY) _____ Age at Event _____

Grade Next Year _____ T-shirt Size: YS YM YL S M L XL 2XL 3XL

Number of Years Attended This JA Program: 0 1 2 3 4 5+

Parent/Guardian 1

First Name_____ Last Name_____ Relationship to Participant

_____

Street Address (child's primary address) _____ P.O. Box/Apt #_____

City _____ State _____ ZIP _____

Email Address _____ Cell Phone _____

Home Phone _____

Employer (if applicable) _____ Work Phone _____

Parent/Guardian 2

First Name_____ Last Name_____ Relationship to Participant

_____

Street Address (if different from above) _____ P.O. Box/Apt #_____

City _____ State _____ ZIP _____

Email Address _____ Cell Phone _____

Home Phone _____

Employer (if applicable) _____ Work Phone _____

Emergency Contact (if Parent(s)/Guardian(s) Unavailable)

Emergency Contact 1

First Name _____ Last Name _____Relationship to Participant

_____

Street Address _____ P.O. Box/Apt #_____City _____ State _____

ZIP _____Email _____Cell Phone _____ Home Phone

_____

Does this person have permission to pick up your child from camp? Yes No

Emergency Contact 2

First Name _____ Last Name _____Relationship to Participant

_____

Street Address _____ P.O. Box/Apt #_____City _____ State _____

ZIP _____Email _____Cell Phone _____ Home Phone

_____

Does this person have permission to pick up your child from camp? Yes No

Personal Information

Has this participant been away from home (overnight) before? No Yes

How does this participant feel about going to this JA program? Is he/she looking forward to seeing/rooming with any particular friends? _____

_____

Swimming Ability

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Excellent

Sleeping Habits

- ☐ Light
- ☐ Heavy
- ☐ Snores
- ☐ Bed Wetter (bring protection)
- ☐ Falls Out of Bed
- ☐ Needs Night Light
- ☐ Sleep Walks
- ☐ Other _____

Communication

Do you anticipate behavioral/social issues to arise? No Yes

Please list any communication problems or behavioral problems that might affect this participant's experience at this event or in a group. _____

_____

Please provide tips and techniques for when your child gets upset. _____

_____

Endurance

Does your child tire easily? No Yes

Can your child endure a normal school day? No Yes

Does your child have any activity restrictions? No Yes _____

Activities of Daily Living

Eating: able to do without help needs assistance requires additional time

Dressing: able to do without help needs assistance requires additional time

Bathing: able to do without help needs assistance requires additional time

Describe an average day (awakening until bedtime) when this participant may be having difficulties from his/her condition (e.g., significant morning stiffness, painful joints, fatigue, a "bad day"). How do you help lessen the symptoms (e.g., heating pad, ice, rest, medications, warm shower, etc.)?

_____

_____

Interests

Just for fun! Tell us about the participant's favorite…

Color _____ Musician/Band _____ School Subject _____

Movie _____ Food _____ Song _____

TV Show _____ Vacation _____ Animal _____

Health Information

Type of arthritis/childhood rheumatic disease _____ Age at diagnosis _____

Additional diagnoses (this will not prevent your child from participating, but allows us to help your child have a better experience while attending our camp program) _____

_____

Participant's height _____ Participant's weight _____

Date of last arthritis flare? (MM/DD/YY) _____ Area(s) involved? _____

Overall, how well do you think your child's arthritis/rheumatic disease is currently controlled?

0 1 2 3 4 5 6 7 8 9 10

Poor Fair Very Well

Which of the following has this participant had, or now has?

Health History	No	Yes	Explanation of "Yes" Answers
ADD or ADHD			
Asthma/Wheezing/Shortness of Breath			
Autism Spectrum Disorder			
Bleeding/Clotting Disorders			
Diabetes			
Depression/Anxiety			
Dizziness/Fainting			
Ear Infections (frequent)			
Eating Disorders			
Eye/Vision Problems			
Gastrointestinal Problems			
Heart Problems/Chest Pain			
High Blood Pressure			
Kidney Problems			
Lung Problems			
Migraines/Headaches			
Menstrual Cycle/Period Problems			
Mononucleosis ("mono") (past 12 months)			
Seizures/Convulsions			
Skin Problems/Rashes			
Surgery/Serious Injuries			

Suicidal Watch			
Surgery			
Thyroid Problems			
Recent Hospitalization (past 2 years)			
Recent Infectious Disease			
Recent International Travel (past 9 months)			
Other _____			

Diet, Nutrition

- ☐ No Food Restrictions
- ☐ Vegetarian
- ☐ Lactose Intolerant
- ☐ Gluten Intolerant
- ☐ Other _____

Allergies

- ☐ Insect Bites or Stings
- ☐ Foods
- ☐ Animals
- ☐ Medications
- ☐ Air Pollutants/Seasonal Allergies
- ☐ Other _____
- ☐ No Known Allergies

Describe the reaction and management of the reaction for any allergy boxes checked above.

_____

_____

Does this participant wear glasses, contacts or protective eyewear? No Yes

Adaptive Equipment: List any adaptive equipment or ambulatory devices used.

_____

_____

Physical Therapy: Describe physical therapy regimen and frequency (must be self-directed during JA program). _____

_____

Occupational Therapy: Describe occupational therapy regimen and frequency (must be self-directed during JA program). _____

_____

Mental, Emotional and Social Health

Has this participant seen a professional to address mental/emotional health concerns during the past 12 months? No Yes (please describe)

_____

_____

Has this participant had a significant life event that continues to affect their life? (history of abuse, death of a loved one, family change, adoptions, foster care, new sibling, etc.) No Yes (please describe)

_____

_____

Immunization History: Provide the month and year for each immunization. Copies of immunization forms from health care providers or state or local government agencies are acceptable; please attach to this form.

Immunization	Dose 1 MM/YY	Dose 2 MM/YY	Dose 3 MM/YY	Dose 4 MM/YY	Dose 5 MM/YY	Most Recent Dose MM/YY
Diptheria, Tetanus, Pertussis (DTaP) or (TdaP)						
Tetanus Booster (dT) or (TdaP)						
Mumps, Measles, Rubella (MMR)						
Polio (IPV)						
Haemophilus Influenzae Type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken Pox) ☐ Had Chicken Pox Date:						
Meningococcal Meningitis (MCV4)						

Tuberculosis (TB) Test	Date:	☐ Negative ☐ Positive

Medication Form

Does this participant know the medications they take? No Yes

Does this participant know dosages and schedule of his/her medications? No Yes

Is this participant aware of his/her medications' potential side effects? No Yes

Medication Administration Record

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies.

☐ This participant will not take any medications while at the JA program

☐ This participant will take the following medication(s) while at the JA program

Name of medication	Date started this med	When it is given	Amount or dose given	How it is given	OFFICE USE ONLY: Distribution (PRN check box, initial, circle when given)	OFFICE USE ONLY: Comments
		☐ Breakfast (B) ☐ Lunch (L) ☐ Dinner (D) ☐ Bedtime (BT) ☐ Other (O):			☐ Day 1 - B L D BT O ☐ Day 2 - B L D BT O ☐ Day 3 - B L D BT O ☐ Day 4 - B L D BT O ☐ Day 5 - B L D BT O ☐ Day 6- B L D BT O	
		☐ Breakfast (B) ☐ Lunch (L) ☐ Dinner (D) ☐ Bedtime (BT) ☐ Other (O):			☐ Day 1 - B L D BT O ☐ Day 2 - B L D BT O ☐ Day 3 - B L D BT O ☐ Day 4 - B L D BT O ☐ Day 5 - B L D BT O ☐ Day 6- B L D BT O	
		☐ Breakfast (B) ☐ Lunch (L) ☐ Dinner (D) ☐ Bedtime (BT) ☐ Other (O):			☐ Day 1 - B L D BT O ☐ Day 2 - B L D BT O ☐ Day 3 - B L D BT O ☐ Day 4 - B L D BT O ☐ Day 5 - B L D BT O ☐ Day 6- B L D BT O	
		☐ Breakfast (B) ☐ Lunch (L) ☐ Dinner (D) ☐ Bedtime (BT) ☐ Other (O):			☐ Day 1 - B L D BT O ☐ Day 2 - B L D BT O ☐ Day 3 - B L D BT O ☐ Day 4 - B L D BT O ☐ Day 5 - B L D BT O ☐ Day 6- B L D BT O	
		☐ Breakfast (B) ☐ Lunch (L) ☐ Dinner (D) ☐ Bedtime (BT) ☐ Other (O):			☐ Day 1 - B L D BT O ☐ Day 2 - B L D BT O ☐ Day 3 - B L D BT O ☐ Day 4 - B L D BT O ☐ Day 5 - B L D BT O ☐ Day 6- B L D BT O	

OFFICE USE ONLY:

Lice check OK? Yes No Temperature OK? Yes No

Routine questions OK? Yes No Approved to attend? Yes No

Please provide any special medication instructions:

_____

_____

Over-the-counter medications: Please review the following list of over-the-counter medications commonly kept with the medical team and mark "Yes" if we have permission to give it to your child. This list is not exhaustive. If there is something specific you do not want us to give to your child, please let us know.

Medication	No	Yes
Acetaminophen (Tylenol)		
Phenylephrine Decongestant (Sudafed PE)		
Antihistamine/Allergy Medicine		
Diphenhydramine Antihistamine/Allergy Medicine (Benadryl)		
Sore Throat Spray		
Lice Shampoo or Cream (Nix or Elimite)		
Calamine or Hydrocortisone Cream		
Laxatives for Constipation (Ex-Lax)		
Ibuprofen (Advil, Motrin)		
Naproxen (Aleve)		
Pseudoephedrine Decongestant (Sudafed)		
Guaifenesin Cough Syrup (Robitussin)		
Dextromethorphan Cough Syrup (Robitussin DM)		
Generic Cough Drops		
Antibiotic Cream (Neosporin)		
Aloe		
Bismuth Subsalicylate for Diarrhea (Kaopectate, Pepto-Bismol)		
Loperamide HCL for Diarrhea (Imodium AD)		
Tums or Antacids		
Sunscreen		
Eye Wash		
Other _____		

What have we forgotten to ask? Please list ANYTHING else you think we should know about the participant._____

_____

_____

_____

Physician Information

Pediatric Rheumatologist _____ Office Phone _____

Primary Physician _____ Office Phone _____

Other Health Care Provider/Therapist_____ Office Phone _____

Permission to contact physician(s)

Please initial here to give our medical team permission to contact this participant's pediatric rheumatologist, primary physician or other doctor with any questions pertaining to his/her health. This may include, but is not limited to, disease diagnosis, recent flares, medication changes, etc.

Parent/Guardian Initials: _____

Insurance Information

Insurance coverage for participant accidents or illness while participating in JA programs is the responsibility of the participant's family and required in order to attend our JA camp.

Is this participant covered by family medical/hospital insurance? Yes No

Health Insurance Company _____ Policy # _____

Name of Policy Holder _____ Subscriber _____

Insurance Company Phone Number _____

Transportation

Parents/guardians are responsible for the transportation of campers to and from Bradford Woods. Drop off and check in of campers will begin July 6th at 2pm EST. Pick up time of campers will be July 8th at 11am EST.

Physician Medical Examination

This form is to be filled out by a licensed physician (pediatric rheumatologist or other) and **returned by 05/15/2016 to: Arthritis Foundation, 615 N. Alabama Street, Suite 430, Indianapolis, IN 46204.**

Name of camp participant_____

Rheumatic diagnosis _____

Other diagnosis (if applicable)_____

Current disease status:

☐ Remission ☐ Well Controlled ☐ Adequately Controlled ☐ Occasional Exacerbation

☐ Frequent Exacerbation ☐ Poorly Controlled ☐ Active Flare

Other: _____

Activity Restrictions (please specify):_____

_____

_____

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in all JA camp activities, except as noted above.

Examining Physician _____ Date: _____

Phone (_____) _____ Email _____

Address _____

Get Involved

Become an Advocate

Do you want to help children with juvenile arthritis? Become an Advocate! You'll receive Action Alerts in your inbox when important arthritis-related issues are debated on Capitol Hill. In five minutes or less, you can send an email to your elected officials and make a difference for kids with arthritis.

☐ Yes, I want to help kids with arthritis! ☐ No, thank you.

Payment

JA camp programs are made possible through funding from the Arthritis Foundation, many generous sponsors/donors and a registration fee for each event. Please confirm this registration by submitting payment. Registration is non-refundable for cancellations made less than one month prior to the event. Scholarships are available to those who request financial assistance by selecting "I am requesting a scholarship" and filling out the additional Scholarship Application page.

- ☐ $$ Registration Fee
- ☐ I am requesting a full scholarship (please complete additional Scholarship Application)
- ☐ I am requesting a partial scholarship (please complete additional Scholarship Application)
- ☐ Sponsor a Scholarship: Help a child attend this JA camp program by adding a full or partial scholarship for another child to your registration total.
  - ☐ Sponsor a $$ partial scholarship for another family
  - ☐ Sponsor a $$$ full scholarship for another family

TOTAL: $_____

Payment Type

- ☐ Check (made payable to "Arthritis Foundation")
- ☐ Money Order
- ☐ Credit Card

- Visa Master Card American Express Discover
- Full Name on Credit Card _____
- Credit Card Number _____
- Expiration Date (MM/DD/YYYY) _____
- CVV _____

Scholarship Application

Is this the first time you have applied for a scholarship for this JA program? No Yes

Please describe the reason you are applying for a scholarship.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How will your child/teen benefit from attending this JA program?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Waivers

Please note, Bradford Woods will also have additional forms that will need to be completed in order for your child to utilize their facilities. These forms will be included in an email to you once your registration is confirmed.