

The Arthritis Foundation's Camp/Teen Retreat Awesome 20XX

Facility Name _____

City, State _____ Date-Date _____

Family Application

TOTAL number of people in your family attending camp (you will be housed together) _____

Number of **Parent(s)/Guardian(s)** in your family attending camp _____

Number of **Children** in your family attending camp _____

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

Parent/Guardian Profile

**PLEASE FILL OUT ONE COMPLETE PARENT/GUARDIAN PROFILE FOR EACH PARENT/GUARDIAN
ATTENDING THIS JA FAMILY CAMP PROGRAM**

Parent/Guardian 1

First Name _____ Last Name _____ Relationship to child with arthritis _____

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

City _____ State _____ ZIP _____

Email Address _____ Cell Phone _____

Home Phone _____

Employer (if applicable) _____ Work Phone _____

T-shirt Size: YS YM YL S M L XL 2XL 3XL

General Health

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			
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			

Family Camp 1

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.

Parent/Guardian 2

First Name _____ Last Name _____ Relationship to child with arthritis _____

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

City _____ State _____ ZIP _____

Email Address _____ Cell Phone _____

Home Phone _____

Employer (if applicable) _____ Work Phone _____

T-shirt Size: YS YM YL S M L XL 2XL 3XL

General Health

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			
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.

Child Profile

FILL OUT ONE COMPLETE CHILD PROFILE FOR
EACH CHILD ATTENDING THIS JA PROGRAM

Child 1

First Name _____ Last Name _____ Gender _____ Age at event _____

Date of birth (MM/DD/YYYY) _____ Grade for the **XXXX** school year _____

Relationship to Child With Arthritis: Self Sibling Other

T-shirt Size: YS YM YL S M L XL 2XL 3XL

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

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 this child tire easily? No Yes

Can this child endure a normal school day? No Yes

Does this child have any activity restrictions? No Yes _____

Interests

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

Color _____ Musician/Band _____ School Subject _____

Movie _____ Food _____ Song _____

TV Show _____ Vacation _____ Animal _____

Check here if this child DOES NOT have arthritis and skip to General Health section

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) _____

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

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). _____

General Health

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			
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

Child 2

First Name _____ Last Name _____ Gender _____ Age at event _____

Date of birth (MM/DD/YYYY) _____ Grade for the **XXXX** school year _____

Relationship to Child With Arthritis: Self Sibling Other

T-shirt Size: YS YM YL S M L XL 2XL 3XL

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

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 this child tire easily? No Yes

Can this child endure a normal school day? No Yes

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

Child 3

First Name _____ Last Name _____ Gender _____ Age at event _____

Date of birth (MM/DD/YYYY) _____ Grade for the **XXXX** school year _____

Relationship to Child With Arthritis: Self Sibling Other

T-shirt Size: YS YM YL S M L XL 2XL 3XL

How does this participant feel about going to this JA program? Is he/she looking forward to

seeing/rooming with any particular friends?

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 this child tire easily? No Yes

Can this child endure a normal school day? No Yes

Does this child have any activity restrictions? No Yes _____

Interests

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

Color _____ Musician/Band _____ School Subject _____

Movie _____ Food _____ Song _____

TV Show _____ Vacation _____ Animal _____

Check here if this child DOES NOT have arthritis and skip to General Health section

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) _____

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

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). _____

General Health

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			
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

Child 4

First Name _____ Last Name _____ Gender _____ Age at event _____

Date of birth (MM/DD/YYYY) _____ Grade for the **XXXX** school year _____

Relationship to Child With Arthritis: Self Sibling Other

T-shirt Size: YS YM YL S M L XL 2XL 3XL

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

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 this child tire easily? No Yes

Can this child endure a normal school day? No Yes

Does this child have any activity restrictions? No Yes _____

Interests

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

Color _____ Musician/Band _____ School Subject _____

Movie _____ Food _____ Song _____

TV Show _____ Vacation _____ Animal _____

Check here if this child DOES NOT have arthritis and skip to General Health section

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) _____

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

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). _____

General Health

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			
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

Child 5

First Name _____ Last Name _____ Gender _____ Age at event _____

Date of birth (MM/DD/YYYY) _____ Grade for the **XXXX** school year _____

Relationship to Child With Arthritis: Self Sibling Other

T-shirt Size: YS YM YL S M L XL 2XL 3XL

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

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 this child tire easily? No Yes

Can this child endure a normal school day? No Yes

Does this child have any activity restrictions? No Yes _____

Interests

Just for fun! Tell us about the participant’s favorite...

Color _____ Musician/Band _____ School Subject _____
 Movie _____ Food _____ Song _____
 TV Show _____ Vacation _____ Animal _____

Check here if this child DOES NOT have arthritis and skip to General Health section

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) _____

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

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). _____

General Health

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			
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

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 program.

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

Health Insurance Company _____ Policy # _____

Name of Policy Holder _____ Subscriber _____

Insurance Company Phone Number _____

Emergency Contact (if parent/guardian is unavailable)

Emergency Contact

First Name _____ Last Name _____ Relationship to Family _____

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

City _____ State _____ ZIP _____

Email Address _____

Cell Phone _____ Home Phone _____

Medications

Medication is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. If any family member listed on this application is taking any medication while at the JA camp program, we agree to follow the local JA camp program guidelines and store medications in the designated location. No Yes

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/family's pediatric rheumatologist, primary physician or other doctor with any questions pertaining to his/her health if the situation arises where the parent/guardian attending the JA family camp program is unavailable. This may include, but is not limited to, disease diagnosis, recent flares, medication changes, etc.

Parent/Guardian Initials: _____

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.

Join Us for Other JA Events

[Enter event specific text here]

Start a JA Family Team

[Enter upcoming JBR or WTCA specific text here]

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

INSERT RISK MANAGEMENT FORMS HERE FOR SIGNATURE