The Arthritis Foundation's Teen Retreat 2016

Camp Widjiwagen Antioch, TN October 22 – October 23, 2016

Participant Application

First Name_____ Nick name_____Last Name _____

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

Grade Next Year _____ T-shirt Size: S M L XL 2XL

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	

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.

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

_____

_____

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 _____		

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 _____

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 your local JA Committee

JA Committees are forming across the state in Knoxville, Memphis and Nashville. The purpose of these committees is to help plan a facilitate JA Family Education Days, JA Camp, outreach to new families, and help improve our overall approach to Juvenile Arthritis in the state of Tennessee.

☐ Yes, I want to be a part of a JA Committee! ☐ No, thank you.

Start a JA Family Team

Whether you participate in the Walk to Cure Arthritis or Jingle Bell Run, we need your help to raise funds and spread awareness! Raising funds and bringing friends and family together to support your child's journey with arthritis is one way that you can help us get closer to a cure, provide crucial programming like Camp AcheAway, and provide resources to new families.

☐ Yes, I want to start a JA Family Team! ☐ No, thank you.