2019 CAMP SPIRIT APPLICATION
EB Winter Adventure Camp in Partnership with the NSCD

Date: _____

Please attach recent photo here!

PARTICIPANT INFORMATION

1. CHILD'S FULL NAME: _____

NICKNAME: _____ DATE OF BIRTH: _____AGE____

2. WITH WHOM DOES THE CHILD LIVE?

NAME(S): _____

RELATIONSHIP TO CHILD: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____WORK PHONE:_____

EMAIL: _____CELL PHONE:_____

CAMPER'S CELL: _____

3. NAME OF CHILD'S LEGAL GUARDIAN(S): _____

RELATIONSHIP TO CHILD: _____

HOME PHONE_____ WORK _____ CELL _____

MOBILITY & AIDS

4. IS CHILD AMBULATORY: List any special areas where he/she might need help, such as stairs.

_____

5. WILL CHILD NEED A WHEELCHAIR ACCESSIBLE ROOM AND BATHROOM?

_____

6. LIST ANY PERTINENT INFORMATION ABOUT THE FOLLOWING AREAS:

A. Distance your child is able to walk (please note if this is with or without assistance)

_____

_____

B. Aid needed for mobility and function: e.g. help with manual chair, transfers, bathing, toileting

_____

_____

7. Transportation at camp will be by car. Therefore we cannot accommodate power chairs. Will your child be bringing a manual chair or other form of assistive device? Yes_____ No_____

Describe:_____

DRESSINGS

8. Families will be expected to send dressings with the child to be used at camp. How often will your child need a bath or shower and dressing change?

OTHER MEDICAL

9. List any other special MEDICAL/HEALTH PRECAUTIONS or special needs.

10. IS CHILD MRSA POSITIVE?

NUTRITION/FEEDING

11. Does child have any G-tube feeding needs?

Night time drips
Daytime feeds/bolus
Water via G-tube
Meds via G-tube
Vitamins/supplements via G-tube

12. Oral intake - Are there any special needs, e.g. blended foods?

13. What textures should be avoided?

MEDICATIONS

14. If child takes medications, please be sure to send all meds with the child. A form for this will be sent out closer to the camp dates. Winter Park is a small mountain town so not all pediatric liquid meds are available.

BOWEL AND BLADDER MANAGEMENT

15. Please describe any special needs your child might have in managing his/her bladder and/or bowel.

_____

ALLERGIES, MEDS, FOOD, OTHER

16. Please describe any allergies child has and remedies. _____

_____

_____

BEHAVIOR

17. If your child has any behavioral issues that may require special techniques or intervention from staff or volunteers, please describe below:

_____

_____

_____

MEASUREMENTS

18. (Please complete with <u>current</u> information)
HEIGHT_____ WEIGHT_____ T-SHIRT SIZE _____

EMERGENCY INFORMATION

19. Please furnish the name of someone outside the home who can be contacted in an emergency if the legal guardian(s) of the child cannot be reached:

NAME: _____ **PHONE:** _____

RELATIONSHIP TO CHILD: _____

ADDITIONAL MEDICAL & HEALTH INFORMATION

20. PRIMARY CARE FAMILY PHYSICIAN: _____ **PHONE:** _____

SPECIALITY: _____

OTHER PHYSICIAN(S) &/OR PERTINENT SPECIALIST(S):

NAME: _____ **SPECIALTY:** _____ **PHONE:** _____

NAME: _____ **SPECIALITY:** _____ **PHONE:** _____

Please send the physician's permission form with this application or have the physician fax it to:
Kaycie Artus 303-526-4102

INSURANCE INFORMATION

Please give us detailed information regarding your child's insurance/third party payer coverage in the event that medical care is necessary during camp.

Most emergencies can be handled by the Ski Patrol at Winter Park Resort or our own physicians and nurses at the camp. Should your child require more extensive care, the 7 Mile Medical Clinic is available at the ski area and the Middle Park Medical Center is close to the cabin. **Payment is required at the time of treatment**. We will contact the participant's family in order to make arrangements for payment should the need arise.

21. To the best of my knowledge, my insurance / third party payer information is as follows and should remain current through the dates of the camp: (Please circle) YES NO

If you indicate **NO** to the above, please explain:

_____

22. Would your child be covered by your insurance carrier for emergency out patient care at Children's Hospital Colorado (Please circle)

YES

NO

If you indicate **NO** to the above, please explain:

_____

23. INSURANCE COVERAGE

PRIMARY INSURANCE (First insurance to be billed):
Name of Insurance Company:_____
Street Address:_____City_____State_____Zip_____
Name of Insured (person who carries coverage):_____
Subscriber or Social Security #:_____Policy or Group#_____

SECONDARY INSURANCE (Second insurance to be billed):
Name of Insurance Company:_____
Street Address:_____City_____State_____Zip_____
Name of Insured (person who carries coverage):_____
Subscriber or Social Security #:_____Policy or Group#_____

MEDICAID OR MEDICARE PATIENT:

What is the patient's Medicaid State I.D. #:_____
Medicaid program_____

CURRENT CONSENT

I / we understand that information provided in this application and documentation about my child's participation in Camp Spirit will be shared with volunteers and staff from TCH and other participating hospitals and Winter Park NSCD.

I / we agree to follow the protocol for Camp Spirit, EB Winter Adventure Camp and participate in the program as described, including: promoting the child's cooperation and acceptance of ski instruction and participation in all activities, adhering to attendance guidelines, being responsible for drop off and pick up at the designated spot, and for providing appropriate winter clothing

In the event I can't be reached in an **emergency**, I hereby give permission to the physician selected by the camp director to secure proper medical care and surgical treatment, including any diagnostic test for my child as named below.

Child's/Camper's name	**Date**
Signature of Parent or Legal Guardian	**Date**
Signature of Parent or Legal Guardian	**Date**

COMMENTS

25. Is there anything else we should know? Your comments and suggestions regarding the camp are most welcome and very valuable.

PLEASE RETURN THIS COMPLETED APPLICATION TO:

KAYCIE ARTUS
2429 BITTERROOT LANE
GOLDEN, COLORADO 80401

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT KAYCIE AT 303-981-1320