TLC CAMP CAMPER APPLICATION

PLEASE fill out ALL pages of the application COMPLETELY and PRINT CLEARLY

Child's Name _____ M / F ___/___/___
First MI Last Gender Birth date (Mo/Day/Yr)

Home Address _____
Street City State/Zip Code

Telephone __(____)_____(____)_____
Primary number Alternate number

Shirt Size (circle one) **Child** S M L **Adult** S M L XL XXL

Parent/Guardian Signature _____ _____
Relationship: Mother Father Guardian Printed name

Physician's signature _____ _____
Printed name

_____
Name of hospital/clinic

Please use this checklist to ensure that all forms listed below are completed and signed by parent/guardian and doctor and have returned by **May 15**.

1. ___ **Application** with parent/guardian printed name and signature
2. ___ **Physical Examination** completed and signed by physician
3. ___ **Medical Consent** signed by parent/guardian
4. ___ **Medical History** of cancer patient and sibling (completed even if child's treatment is over)
5. ___ **Port-a-Cath/Broviac/Central Line Catheter** completed and signed by physician; reviewed and initialed by parent/guardian
6. ___ **Waiver** signed by parent/guardian

If any of the above is returned to us incomplete, they will be returned to you for completion and the application will not be processed until **all** information is received.

TLC CAMP MEDICAL CONSENT
For all Campers and Siblings

To be completed by the Parent/Guardian and returned with application.

Child's name _____ M / F _____-_____-_____
First MI Last Birth date (Mo – Day – Yr)

_____ _____-_____-_____
Diagnosis Date diagnosis was first made

Parent/ Guardian _____ Mother Father Guardian

_____ Mother Father Guardian
Relationship

Telephone (____) _____ (____) _____ (____) _____
Home Mom work Dad work

Telephone (____) _____ (____) _____ (____) _____
Alternate Mom cell Dad cell

Email _____

Child lives with: Mother Father Guardian

If parents are divorced, which parent has legal custody? Mother Father Joint/Shared
Person other than parent/guardian to contact in case of an emergency and parent/guardian cannot be reached:

Other contact _____
Name Relationship

Telephone (____) _____ (____) _____ (____) _____
Primary Alternate Cell

Hematologist/Oncologist _____

Office address _____

Telephone (____) _____ Emergency phone (____) _____

Primary Care Physician _____

Office address _____

Telephone (____) _____ Emergency phone (____) _____

MEDICAL TREATMENT CONSENT INFORMATION: To be used by medical staff and/or emergency room personnel.

I hereby grant permission for the medical staff to administer routine care, medications, and determine need for lab/x-ray Studies for my child, as well as any emergency care required. **Yes No**

Child's name: _____

Parent/Guardian signature _____ Date _____-_____-_____
Relationship: Mother Father Guardian (Mo – Day – Yr)

TLC CAMP MEDICAL HISTORY

For all Campers and Siblings

To be completed by the Parent/Guardian and returned with application.

Child's name _____ M / F _____-_____-_____
First MI Last Birth date (Mo – Day – Yr)

_____ _____-_____-_____
Diagnosis Date diagnosis was first made

Hospital/
Clinic _____

If your child no longer takes chemotherapy or radiation treatment, when was treatment ended? Date _____

Please circle as it pertains to your child:

1.	Has a port-a-cath	Yes	No	10.	Has a problem with bedwetting	Yes	No
2.	Has a Broviac/cental line catheter	Yes	No	11.	Has behavioral problems	Yes	No
3.	Has VP shunt or Ommaya Reservoir	Yes	No	12.	Uses crutches (if yes, send with child)	Yes	No
4.	Has had an amputation	Yes	No	13.	Uses a wheelchair (if yes, send with child)	Yes	No
5.	Has had a limb salvage procedure	Yes	No	14.	Has had a seizure in the last 3 years	Yes	No
6.	Has had a transplant _____	Yes	No	15.	Cancer or leukemia has relapsed	Yes	No
7.	Has a problem with hearing/wears a hearing aid	Yes	No	16.	Has Asthma	Yes	No
8.	Child is legally blind	Yes	No	17.	Has Diabetes Mellitus	Yes	No
9.	Wears glasses or contact lenses	Yes	No	18.	Has Diabetes Insipidus	Yes	No

If you answered yes to any of the above, please explain.

_____

_____

_____

Any additional medical problems, please explain

_____

_____

Does you child need any assistance with activities of daily living (dressing, toileting, etc)? Yes No
Explain

_____

_____

_____

Please list any food restrictions

_____

_____

Please list and describe any operations you child has had and approximate date

_____

_____

Please list and describe any serious illnesses or procedures your child has had in the past two years

_____

_____

Please list any physical restrictions or limitations to activity (e.g., no contact sports or exceptionally rough activity, no swimming, required to wear ear plugs, etc.)

_____

_____

MEDICATION FORM

Name _____

List all medications to be taken at camp.

Medication Name	Dose	Date at Camp	Time at Camp

Will the child be responsible for administering medication? Yes No

When sending medication to camp, send only the amount to be administered. Place medication in a zip-lock plastic bag that is labeled with the person's name, the name of the medication, the dosage of each pill, the dosage to be administered and the date and time the medication should be administered.

*** PLEASE BE VERY SPECIFIC ***

Example of what to write on zip-lock bag:

Camper: Jane Doe
Medication: Prednisone (2mg. Tablets)
On Monday give 2 tablets (4mg.) of Prednisone at noon with lunch. She also takes it with milk.

MEDICATIONS:
It is expected that each family will supply **ALL** of their child's routine medications including anti-nausea drugs, dressing materials, Broviac flushing supplies needed. Unless indicated otherwise below, the medical staff will store and dispense these medications to you child, and will maintain a full supply of emergency medications. Please send appropriate extra oral medication in case a dose is not kept down or needs to be repeated. In order to allow your child to participate in and enjoy the program activities as much as possible, whenever appropriate, the scheduling of IV chemotherapy and blood work, other than routine counts, my be re-scheduled by your child's physician during the camp session.

Because of the nature of camp activities, it is required that the medical staff supervises medication for all campers. Campers will be allowed to keep "as needed medications" when appropriate. Parents should discuss special needs of your child at camp check in.

Please indicate any further information about your child's medical needs that you feel the medical care team and your child's Sr. counselor should know:

_____
_____
_____
_____
_____

Parent/Guardian Signature _____ Date _____-_____-_____
Relationship: Mother Father Guardian (Mo – Day – Yr)

*** Application will **NOT** be processed without this form ***

TLC CAMP PHYSICAL EXAMINATION

For all Campers and Siblings

To be completed by the PHYSICIAN/NURSE PRACTITIONER and returned with application.

Child's name _____ _____-_____-_____
First MI Last Exam date (Mo – Day – Yr)

_____ _____ _____
Hem / Onc Diagnosis B/P Height Weight

Date diagnosis first made _____-_____-_____ Currently on therapy for cancer? Yes No

___ General exam, normal

___ Abnormal findings, please specify

_____

_____

_____

___ None

___ Active and/or recent medical issues, please specify

_____

_____

_____

___ None

Allergies

_____

_____

_____

LABORATORY VALUES (if indicated) ____ N/A

	Normal	Abnormal	Comment
CBC	_____	_____	_____
Chemistries	_____	_____	_____

Date of most recent Tetanus immunization _____

Date of Chicken Pox/Varicella Vaccine _____

MEDICATIONS

Please include routine and PRN medications.

Medications	Dose	Route	Frequency

On the basis of this examination on this day, I approve this child's participation in the TLC CAMP day camp.

_____With no limitations

_____ With the following limitations _____

_____

Physician/Nurse Practitioner signature _____ Date _____

****Application will **NOT** be processed without these forms or without a doctor's signature****

Port-a-Cath/Broviac/Central Line Catheter

Child's name _____ _____/_____/_____
First MI Last Exam date (Mo/Day/Yr)

Child has a port-a-cath Yes No

Child has a Broviac/central line catheter Yes No

***** Fill out the following ONLY if you answered YES to the previous statement *****

Does this child do his/her own central line care (flushing, dressing)? Yes No

Single/Double Lumen _____

How often is it flushed? _____ What days of the week? _____ Flush AM / PM

When is dressing changed? _____

This child has my permission to swim in a chlorine-treated pool. Yes No

Physician approval for swimming in pool

Physician/Nurse Practitioner signature _____ _____
Date (Mo/Day/Yr)

Parent/Guardian reviewed: _____
Initials

*** Application will NOT be processed without this form or without doctor's signature ***

SPONSORED BY THE
LOMBARD JUNIOR WOMEN'S CLUB

Waiver and Consent Form

Please read this form carefully. Be aware that by signing to participate in the above program, you will be waiving and releasing all claims for injuries you might sustain arising out of the above program.

I understand that the TLC Camp, Inc. program will include not only normal activities conducted on the campgrounds but also certain field trips and other activities outside the campgrounds, which will require transportation to and from these locations. I recognize and acknowledge that there are certain risks of physical injury to participants in the above program and I agree to assume the full risk of any such injuries, damages, or loss, regardless of severity, which I or my child may sustain as a result of participating in any activities connected or associated with any such program.

I waive and relinquish all claims I may have against the Lombard Park District, the Lombard Junior Women's Club and their officers or agents, servants, employees, volunteers and medical staff as a result of participating in the above program. I hereby fully release and discharge the Lombard Park District, the Lombard Junior Women's Club and all of their officers or agents, servants, employees, volunteers and medical staff from any and all claims from injuries, damage or loss which I may have or which may accrue to me on account of my participation or the participation of my child or children in the above program. I further agree to indemnify and hold harmless and defend the Lombard Park District, the Lombard Junior Women's Club and their officers or agents, servants, employees, volunteers and medical staff from any and all claims resulting from injuries, damages or losses sustained by me or by my child or children, and arising out of, connected with, or in any way associated with the activities on the TLC Camp, Inc. program.

I understand that every precaution is taken to protect the safety of each participant. I agree to emergency treatment at Good Samaritan Hospital, 3815 S. Highland Ave., Downers Grove, Illinois 630-275-5900 and the administration of medication by Lombard Park District and Lombard Junior Women's Club agents as prescribed by a physician and or nonprescription medications as may be required to safeguard the health and well-being of the participant if it is necessary during the activity (is). I further understand that the Lombard Park District and the Lombard Junior Women's Club carry no accident coverage on participants and that immediate medical attention and/or hospitalization will be the sole responsibility of the individual in question and/or the parent or guardian.

I understand that unless specifically stated in writing at the time of this registration, photographs of participants may be taken. I realize that our rights to privacy will be protected in all photographs and publications of the Lombard Park District and Lombard Junior Women's Club activities. I have been made to understand that no personal information other than first name and hometown will be released and this meets my approval.

I have read and fully understand the Lombard Park District and Lombard Junior Women's Club policies pertaining to participation in the TLC Camp, Inc. program that the above information details and waiver and release all claims.

I fully understand that TLC Camp, Inc. hours are 9:00 am to 3:00 pm Monday through Thursday and 9:00 a.m. to 7:00 p.m. Friday during the week of camp.

Printed Name of Applicant _____

Signature of Applicant_____Date_____

Signature of Parent/Guardian_____Date_____
(If applicant is under age 21)

Rev 1/13