The Hole in the Wall Gang Camp

2016 Family Camp Application

Who can come?
- Families with a child(ren) between the ages of 5 and 15 who have the condition we are serving that weekend.
- Immediate family members only.
- Siblings can be any age.

What happens during Family Camp?
- Fun, fun, fun for the whole family!
- Camp activities (fishing, arts & crafts, woodworking, climbing tower, and more)
- Evening activities (campfire, games, stage night)
- Parent Chat

What is the cost?
- Free of charge, thanks to the generosity of our sponsors and donors.

Where do we stay?
- Families are housed together as a family unit.
- Each family has private sleeping quarters and bathroom.
- The Hole In The Wall Gang Camp is a non-smoking and alcohol-free facility.

Medical coverage:
- Parents and Guardians are responsible for the medical care of their child(ren).
- Medical staff will be available on site for support as needed 24/7 during the weekend.

Transportation:
- Transportation assistance may be provided depending on the region. Any questions, please contact us.

2016 Family Camp Weekend

Family Camp: June 2 – June 5, 2016
The Hole in the Wall Gang Camp
Family Camp Application Checklist

The application must be complete before it can be reviewed. A complete application contains three (3) parts. Please note that incomplete information will delay your application. We appreciate your timely response in obtaining missing information.

Part I - General Information: To be completed by Parent or Guardian.

Part II - Family Medical and Consent Form: To be completed by Parent or Guardian.

- A form MUST be completed for EACH family member who will be attending (this does not need to be signed by a healthcare provider).
- It is important that each family medical form is completed thoroughly as our medical team considers the information provided to determine participation of certain activities.
- With the recent outbreaks of Measles and Mumps around the US it is important that everyone who comes to THITWGC be fully immunized against these diseases. You are immune if you received 2 vaccinations against each of these diseases or if you have had the disease and it was diagnosed by a health care provider. Please complete the immunization portion of the medical form for each family member attending (including adults) and/or send a copy of each person's immunization record.

PART III – Medical Information: To be completed by diagnosed child’s Health Care Provider (Primary Care or Sub-Specialty Physician or Nurse Practitioner)

a. Medical Form: General medical information, physical exam and medications
b. Immunization Form
c. Diagnosis Specific Form
d. Catheter or Infusion Pump Form: if applicable

**Please Note**

- You will be notified when the application is received.
- Due to the number of applications, not every family that applies can be accepted.
- If your family is not accepted, you will be placed on a waitlist.
- Acceptances will be mailed 2-4 weeks prior to the Family Weekend.
- If your family is accepted, we kindly ask that all family members stay at camp for the entire weekend.
- Family weekends are for immediate family members only.

Applications may be mailed or faxed*:
The Hole in the Wall Gang Camp
Camper Admissions
565 Ashford Center Road
Ashford, CT 06278
Fax to: (860) 429-7295

Questions? Please call us at: 860-429-3444 or visit our website at www.holeinthewallgang.org

*Please call Camp office to confirm fax has been received.
1. Which program are you applying for?
   ☐ Family Camp: June 2 – June 5, 2016

2. Has your child or family previously attended Camp? ☐ No ☐ Yes, When? _______________________________

3. Do you need assistance with transportation for the weekend? ☐ Yes ☐ No

4. Camper(s) (Child with the condition we are serving):
   Camper(s) Name: ___________________________________________ Birth Date: __________________________
   Gender: __________________ Diagnosis: ___________________________________________________________

5. Parent or Guardian Information (names of those who are attending):
   Parent/Guardian Name: ___________________________________ Birth Date: __________________ Gender ______
   Relationship to Camper: ___________________________ Cell Phone: _________________________________
   Home Phone: ___________________________ Email Address: ________________________________
   Primary Language: ___________________________ Do you speak English? ☐ Yes ☐ No
   Parent/Guardian Name: ___________________________________ Birth Date: __________________ Gender ______
   Relationship to Camper: ___________________________ Cell Phone: _________________________________
   Home Phone: ___________________________ Email Address: ________________________________
   Primary Language: ___________________________ Do you speak English? ☐ Yes ☐ No
   Primary Mailing Address: Street: ___________________________ City: __________________ State: ___________ Zip: ________

6. Who has legal custody for all the children under 18? _______________________________________________

7. Additional Family Members attending (immediate family only):
   Name: ___________________________________________ Birth Date: ________ Gender ______
   Name: ___________________________________________ Birth Date: ________ Gender ______
   Name: ___________________________________________ Birth Date: ________ Gender ______
8. **Emergency Contact:** (other than family member attending the weekend)

Name: ___________________________________________ Relationship to child: ________________________________

Phone: ___________________________________________ Alt. Phone: ________________________________________

9. **Clinic Information:**

Name of clinic or hospital: __________________________________________

Who are your child’s health care providers?

Specialist: ___________________________________________ Phone: __________________________

Primary Care: ___________________________________________ Phone: __________________________

10. **Please check any special needs your family may have:**

☐ Refrigerator for medications ☐ Mobility Issues ____________________________

☐ First Floor Housing ☐ Dietary Needs ____________________________

☐ Other ____________________________

11. **Please share any additional information about your family:** (fun facts, birthdays, anniversaries, big news, etc.)

________________________________________________________________________________________

________________________________________________________________________________________

**Media Release & Special Permissions**

I do____ or I do not____ (select one) give my permission and approve the use of my family’s image, name, biographical information and/or audio recording (and/or my child’s image, name, biographical information or audio recording if subject is a minor) to be used by The Hole In The Wall Gang Camp as part of its fundraising efforts, advertising, publicity, promotion or any other use. I understand and agree that my image, information and/or audio recording may appear in any media now known or hereafter invented including but not limited to print materials, video, online presentations or other media. I hereby waive any right to inspect and approve the uses to which it may be applied. Nothing herein will constitute any obligation on The Hole In The Wall Gang Camp to use any of the above rights.

I do_____ or I do not_____ (select one) give my family and/or my child permission to participate in confidential and voluntary program evaluation at The Hole in the Wall Gang Camp.

I do_____ or I do not_____ (select one) wish to receive informational materials from Camp such as newsletters and other publications.

This permission/authorization, including all of its subparts, is effective until revoked in writing.

**Consent for Disclosure of Information**

I am aware that the Camp has outreach programming including, but not limited to Hospital Outreach Program and CampOut. I understand that should my child ever participate in these Programs, the Outreach Staff may have access to information about my child which may be relevant to his/her participation in Camp programs. I understand that only the minimum necessary information will be disclosed and that all reasonable steps are taken to protect the privacy and confidentiality of my child's information.

I do_____ or do not_____ (select one) give my permission to the sharing of any relevant information between Outreach Staff and Camp staff. For more information about Outreach Programs please visit our website: www.holeinthewallgang.org

Parent/Guardian Signature________________________________________ Date__________________
This form must be completed for EACH ADULT (18 and over) coming to camp. Please make copies as necessary.

It is important that both forms are completed thoroughly as the medical team considers the information provided to determine participation for certain activities.

1. Name: _________________________________________ Birth Date: ____/____/_________ Age ___________

2. Your relationship to camper: __________________________________________________________________

3. Drug allergies: ______________________________________________________________________________

4. Food allergies: ______________________________________________________________________________

5. Special Diet Needs: __________________________________

6. Medications: _______________________________________________________________________________
   ______________________________________________________________________________________________

7. Please list any past or ongoing medical conditions and/or considerations:________________________________
   ______________________________________________________________________________________________

8. Please list any past or on-going behavioral and/or mental health concerns:_______________________________
   ______________________________________________________________________________________________

9. Activity limitations or restrictions:______________________________________________________________
   ______________________________________________________________________________________________

10. Does participant use any mobility devices (wheelchair, walker, crutches, etc)? □ NO □ YES
    If yes, please explain__________________________________________________________________________

11. IMMUNIZATIONS: please attach a copy of your immunization records

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
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<th>Dates of vaccine, titers, or illness</th>
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<td>Have you had the Tdap vaccine?</td>
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*2 doses of vaccine are required. If you were born before 1957 you are considered immune
**2 doses of vaccine are required

FAX COMPLETED FORM TO (860) 429-7295
Consent Form – ADULT (18 and over)

This form MUST be completed for EACH ADULT (18 and over) coming to camp.
Please make copies as necessary.

Name: ________________________________  Birth Date: ___/___/_______  Age _______

Mailing Address: (if different from address listed under contact information)

Street: ___________________________________________ __________________________________________

City: ________________________________ State: ____________ Zip: ____________

CONSENT FOR MEDICAL TREATMENT

I hereby grant, in the event it is necessary, permission to the health care staff at The Hole in the Wall Gang Camp or consulting physicians; to obtain laboratory tests, x-rays, administer routine and other medication, and to provide any emergency or routine care required for ____________________________________

(Adult’s Name)

CONSENT FOR ACTIVITIES

I do _____ or I do not _____ (select one) agree that I and/or my child is authorized to participate in any and all officially administered, sponsored or sanctioned activities at The Hole In The Wall Gang Camp, including, but not limited to: (1) Supervised boating and fishing, (2) Supervised wall climbing, (3) archery. Certain medical conditions may limit participation in specific programs and may require additional medical authorization from your medical provider.

For more program details, including a full list of activities offered on family weekends please visit our website:  www.holeinthewallgang.org

I/We would like to discuss the following program areas further: ______________________________

This form may be photocopied for use outside of camp.

Signature: ____________________________________________  Date: ______________________

Relationship: ____________________________________________  Date: ______________________

FAX COMPLETED FORM TO (860) 429-7295
This form must be completed for EACH ADULT (18 and over) coming to camp.
Please make copies as necessary.

It is important that both forms are completed thoroughly as the medical team considers the information provided to determine participation for certain activities.

1. Name: _________________________________________ Birth Date: ___/___/_______ Age ___________

2. Your relationship to camper: _______________________________________________

3. Drug allergies: ______________________________________________________________________________

4. Food allergies: ______________________________________________________________________________

5. Special Diet Needs: __________________________________________________________________________

6. Medications: _______________________________________________________________________________

____________________________________________________________________________________________

7. Please list any past or ongoing medical conditions and/or considerations:

____________________________________________________________________________________________

8. Please list any past or on-going behavioral and/or mental health concerns:

____________________________________________________________________________________________

9. Activity limitations or restrictions:

____________________________________________________________________________________________

10. Does participant use any mobility devices (wheelchair, walker, crutches, etc)? ☐ NO ☐ YES
    If yes, please explain____________________________________________________________

11. IMMUNIZATIONS: please attach a copy of your immunization records

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*2 doses of vaccine are required. If you were born before 1957 you are considered immune
**2 doses of vaccine are required

FAX COMPLETED FORM TO (860) 429-7295
THE HOLE IN THE WALL GANG CAMP

Consent Form – ADULT (18 and over)

This form MUST be completed for EACH ADULT (18 and over) coming to camp.
Please make copies as necessary.

Name: _______________________________ Birth Date: ___/___/_______ Age _______

Mailing Address: (if different from address listed under contact information)
Street: ___________________________________________ __________________________________________
City: ___________________________ State: __________ Zip: __________

CONSENT FOR MEDICAL TREATMENT

I hereby grant, in the event it is necessary, permission to the health care staff at The Hole in the Wall Gang Camp or consulting physicians; to obtain laboratory tests, x-rays, administer routine and other medication, and to provide any emergency or routine care required for ________________________________________ (Adult’s Name)

CONSENT FOR ACTIVITIES

I do ___ or I do not ___ (select one) agree that I and/or my child is authorized to participate in any and all officially administered, sponsored or sanctioned activities at The Hole In The Wall Gang Camp, including, but not limited to: (1) Supervised boating and fishing, (2) Supervised wall climbing, (3) archery. Certain medical conditions may limit participation in specific programs and may require additional medical authorization from your medical provider.

For more program details, including a full list of activities offered on family weekends please visit our website: www.holeinthewallgang.org

I/We would like to discuss the following program areas further: __________________________

This form may be photocopied for use outside of camp.

Signature: ___________________________________ Date: __________________

Relationship: ___________________________________ Date: __________________

FAX COMPLETED FORM TO (860) 429-7295
This form must be completed for EACH CHILD, including camper (17 and under) coming to camp. Please make copies as necessary.

It is important that both forms are completed thoroughly as the medical team considers the information provided to determine participation for certain activities.

1. Name: _________________________________________ Birth Date: ____/____/_________ Age ___________

2. Child’s relationship to camper: ________________________________________________________________

3. Drug allergies: ____________________________________________________________________________

4. Food allergies: ______________________________________________________________________________

5. Special Diet Needs: ___________________________________________________________________________

6. Medications: _______________________________________________________________________________

7. Please list any past or ongoing medical conditions and/or considerations:

____________________________________________________________________________________________

8. Please list any past or on-going behavioral and/or mental health concerns:

____________________________________________________________________________________________

9. Activity limitations or restrictions:

____________________________________________________________________________________________

10. Does participant use any mobility devices (wheelchair, walker, crutches, etc)?  ☐ NO  ☐ YES

If yes, please explain______________________________________________________________

11. Is the child’s development appropriate for his or her age?  ☐ YES  ☐ NO

If No, at what age does child function? ________________ Please explain:_________________________

____________________________________________________________________________________________

12. IMMUNIZATIONS: please attach a copy of immunization records

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*2 doses of vaccine are required

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Name: _____________________________________ Birth Date: ____/____/_________ Age _______

Mailing Address: (if different from address listed under contact information)

Street: ___________________________________________ ___________________________________

City: __________________________________________ State: __________ Zip: ____________

CONSENT FOR MEDICAL TREATMENT

I hereby grant, in the event it is necessary, permission to the health care staff at The Hole in the Wall Gang Camp or consulting physicians; to obtain laboratory tests, x-rays, administer routine and other medication, and to provide any emergency or routine care required for _________________________________ (Child’s Name)

CONSENT FOR ACTIVITIES

I do _____ or I do not _____ (select one) agree that my child is authorized to participate in any and all officially administered, sponsored or sanctioned activities at The Hole In The Wall Gang Camp, including, but not limited to: (1) Supervised boating and fishing, (2) Supervised wall climbing, (3) archery. Certain medical conditions may limit participation in specific programs and may require additional medical authorization from your medical provider. Please see Diagnosis Specific Form for more information.

For more program details, including a full list of activities offered on family weekends please visit our website: www.holeinthewallgang.org

I/We would like to discuss the following areas further: ________________________________

This form may be photocopied for use outside of camp.

Signature: (Parent/ Guardian of child) ________________________________ Date: ________________

Relationship: (Parent/ Guardian of child) ___________________________________________

FAX COMPLETED FORM TO (860) 429-7295
This form must be completed for EACH CHILD, including camper (17 and under) coming to camp. Please make copies as necessary.

It is important that both forms are completed thoroughly as the medical team considers the information provided to determine participation for certain activities.

Name: ___________________________ Birth Date: ____/____/_________ Age ___________

2. Child’s relationship to camper: ____________________________________________________

3. Drug allergies: __________________________________________________________________

4. Food allergies: __________________________________________________________________

5. Special Diet Needs: __________________________________________________________________

6. Medications: ___________________________________________________________________

__________________________________________________________________________________

7. Please list any past or ongoing medical conditions and/or considerations:

__________________________________________________________________________________

8. Please list any past or on-going behavioral and/or mental health concerns:

__________________________________________________________________________________

9. Activity limitations or restrictions:

__________________________________________________________________________________

10. Does participant use any mobility devices (wheelchair, walker, crutches, etc)? □ NO □ YES

   If yes, please explain _____________________________________________________________

11. Is the child’s development appropriate for his or her age? □ YES □ NO

   If No, at what age does child function? _____________ Please explain:________________

__________________________________________________________________________________

12. IMMUNIZATIONS: please attach a copy of immunization records

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<td></td>
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</table>

*2 doses of vaccine are required

FAX COMPLETED FORM TO (860) 429-7295
This form MUST be completed for EACH CHILD, including camper (17 and under) coming to camp. Please make copies as necessary.

Camper’s Name: ____________________________ Birth Date: ____/____/_______ Age _______

Mailing Address: (if different from address listed under contact information)
Street: ___________________________________________
City: __________________________ State: _______ Zip: _____________

CONSENT FOR MEDICAL TREATMENT

I hereby grant, in the event it is necessary, permission to the health care staff at The Hole in the Wall Gang Camp or consulting physicians; to obtain laboratory tests, x-rays, administer routine and other medication, and to provide any emergency or routine care required for ____________________________

(Camper’s Name)

CONSENT FOR ACTIVITIES

I do ______ or I do not ______ (select one) agree that my child is authorized to participate in any and all officially administered, sponsored or sanctioned activities at The Hole In The Wall Gang Camp, including, but not limited to: (1) Supervised boating and fishing, (2) Supervised wall climbing, (3) archery. Certain medical conditions may limit participation in specific programs and may require additional medical authorization from your medical provider. Please see Diagnosis Specific Form for more information.

For more program details, including a full list of activities offered on family weekends please visit our website: www.holeinthewallgang.org

I/We would like to discuss the following areas further: __________________________________________

This form may be photocopied for use outside of camp.

Signature: (Parent/ Guardian of camper) ____________________________ Date: ______________

Relationship: (Parent/ Guardian of camper) ____________________________________________

FAX COMPLETED FORM TO (860) 429-7295
# PART III- MEDICAL EXAM FORM - Page 1 of 2

**REQUIRED: PHYSICIAN(S) CONTACT AND INFORMATION**

<table>
<thead>
<tr>
<th>Specialty Dr:</th>
<th>Pediatrician/Other Dr:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>Hospital:</td>
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<td>Emergency Phone:</td>
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<td>E-Mail:</td>
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</table>

## GENERAL INFORMATION:

- **Camper Name:** __________________________
- **Birthdate:** __________________________
- **Primary Diagnosis:** ____________________
- **Date of Diagnosis:** ____________________
- **Please List Current Problem(s) or Secondary Diagnoses:** __________________
- **Comments:** __________________________
- **Drug Allergies:** ______________________
- **Food Allergies:** ______________________
- **Environmental Allergies:** (bees, latex etc.) ______________________

Does this child have:

- **Central Venous Catheter** □ Yes □ No If Yes, please complete CV Catheter Form
- **G-tube/J-tube** □ Yes □ No If Yes, please complete Infusion Pump Form
- **TPN** □ Yes □ No If Yes, please complete Infusion Pump Form
- **IV or subcutaneous medications** □ Yes □ No If Yes, please include in medication list

**Please list all surgeries and dates:** __________________________

FAX COMPLETED FORM TO (860) 429-7295
Camper Name: ____________________________ Birthdate: ___________ Date of Exam: ___________

**PHYSICAL EXAM:** Please list any pertinent physical findings or attach a recent history & physical.

Height: ft __________ cm __________
Weight: lbs __________ kg __________
BP __________

Pertinent Findings: ____________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

**MEDICATIONS:**
Complete Physician’s order is required for all medications including OTC and PRN medications that will be administered at camp. Please attach list if more space is needed.

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
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<tbody>
<tr>
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Pertinent Psychosocial Information: ____________________________________________
____________________________________________________________________________
____________________________________________________________________________

Essential laboratory studies to be done while child is at camp _____________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Are there any special suggestions or restrictions for this camper? ____________________________
____________________________________________________________________________
____________________________________________________________________________

**PHYSICIAN’S STATEMENT:**
I have examined ____________________________ and find him/her physically able to attend Camp. I understand the above medical regimen will be followed while the camper is at camp.

__________________________  ____________________________  ____________________________
SIGNATURE OF PROVIDER MANDATORY  PRINT NAME  DATE MANDATORY

Clinic / Day Phone ____________________________  Emergency / On Call Phone ____________________________
### Chicken Pox

*Immunity is REQUIRED unless contraindicated*

Camper is immune by one of the following:
- Clinical Disease  
  Date __________
- Varivax Vaccine #1  
  Date __________
- Varivax Vaccine #2  
  Date __________
- Positive Titer  
  Date __________
- Camper is not immune and the vaccine is contraindicated. *Reason contraindicated:__________________________*

### MMR

*Immunity if REQUIRED unless contraindicated*

Camper is immune by one of the following:
- MMR #1  
  Date __________
- MMR #2  
  Date __________
- Positive Titer  
  Date __________
- Camper is not immune and the vaccine is contraindicated. *Reason contraindicated:__________________________*

### DPT, DT, Tdap (Tetanus & Pertussis)

*4 shot series REQUIRED unless contraindicated  
If ≥ 11 years old Tdap is REQUIRED*

- DPT/DT  
  Date __________
- DPT/DT  
  Date __________
- DPT/DT  
  Date __________
- DPT/DT  
  Date __________
- Tdap  
  Date __________
- Camper is not immune and the vaccine is contraindicated. *Reason contraindicated:__________________________*

### Recommended Vaccines

*We strongly recommend the following vaccines.  
They are not required for Camp attendance*

#### Hepatitis A

- Dose #1  
  Date __________
- Dose #2  
  Date __________

#### Pneumococcal Vaccine

- Pneumovax  
  Date __________  
  Date __________
- Prevnar  
  Date __________  
  Date __________

#### HIB

- Date __________  
  Date __________
- Date __________  
  Date __________

#### Menactra

- Date __________

### Hepatitis B

*3 shot series REQUIRED unless contraindicated*

- Hep B #1  
  Date __________
- Hep B #2  
  Date __________
- Hep B #3  
  Date __________
- Camper is not immune and the vaccine is contraindicated. *Reason contraindicated:__________________________*

### Polio

*3-4 doses REQUIRED unless contraindicated*

- Polio #1  
  Date __________
- Polio #2  
  Date __________
- Polio #3  
  Date __________
- Polio #4  
  Date __________
- Camper is not immune and the vaccine is contraindicated. *Reason contraindicated:__________________________*

### Immunization Exemption

*If the child is exempt from immunizations please explain.__________________________
__________________________
__________________________
__________________________
__________________________
__________________________

---

I certify that this immunization information was transferred from the above-named individual’s medical records.

________________________________
SIGNATURE OF PROVIDER

________________________________
PRINT NAME

________________________________
DATE
PART III – CANCER FORM
MUST BE COMPLETED BY HEALTH CARE PROVIDER

Signature of Provider ___________________________ Print Name ___________________________ Date ___________________________

Camper’s Name ___________________________________ DOB ___________________________

Diagnosis: ___________________________________ Date of Diagnosis: ___________________________

Date of relapse (if applicable) ______________________

Treatment:

Is the child on therapy? □ Yes □ No

If yes, please give details of most recent chemo (date, meds):
________________________________________________________________________________________

If not, when was chemotherapy completed? ___________________________

Has the child had a stem cell transplant? □ Yes □ No

Date ___________________________

Does this child have long term side effects from his/her treatment or disease? □ Yes □ No

If yes, please explain: __________________________________________________________________________

If the child has a central venous catheter please complete CVC Form.

Labs:

Most recent or typical blood counts: Date ___________________________

Hb _____ Hct _____ WBC _____ ANC _____ Plt _____ Other _______________

Laboratory studies to be done while camper is at camp: (Please limit to labs that are essential!)

Date __________ Labs ___________________________________________________________________________

Results to be sent to: Name ___________________________ Fax or Phone ___________________________

Additional Comments:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

PLEASE SEND UPDATED INFORMATION REGARDING TREATMENT AND/OR CARE IF THERE ARE SIGNIFICANT CHANGES PRIOR TO CAMP
(Including relapse, recent chemo, recent labs, etc.)

FAX COMPLETED FORM TO (860) 429-7295
The Hole In The Wall Gang Camp - Family Camp

Part III – Sickle Cell Anemia

Must be completed by health care provider

Signature of Provider ____________________________  Print Name ____________________________  Date ____________________________

Camper’s Name ____________________________  DOB ____________________________

What hemoglobinopathy does the child have? (SS, SC, etc.) ____________________________

What is the child’s baseline room air oximetry? ____________________________

What complications has the child had?

<table>
<thead>
<tr>
<th>Complication</th>
<th>Yes</th>
<th>No</th>
<th>Comments/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent VOC</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Acute Chest Syndrome</td>
<td></td>
<td></td>
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<tr>
<td>Stroke</td>
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<tr>
<td>AVN</td>
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<tr>
<td>Priapism</td>
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<tr>
<td>Splenic Sequestration</td>
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<tr>
<td>Bacteremia/Infection</td>
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<tr>
<td>Gallstones</td>
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<td></td>
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<tr>
<td>Sleep Apnea</td>
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</tbody>
</table>

Does the child have splenomegaly?  □ Yes  □ No  If Yes, spleen size ____________________________

Is this child on a chronic transfusion protocol?  □ Yes  □ No

History of allo/auto antibodies?  □ Yes  □ No  Details ____________________________

History of transfusion reaction?  □ Yes  □ No  Details ____________________________

Please provide most recent or baseline labs: Date ____________________________

Hb ____________________________  Hct ____________________________  Retic ____________________________  WBC ____________________________

CXR ____________________________  Date ____________________________

Pain Protocol:

Mild Pain ____________________________

Moderate (increasing) Pain ____________________________

Severe Pain ____________________________

Additional Information: ____________________________

Fax completed form to (860) 429-7295
The Hole In The Wall Gang Camp - Family Camp

PART III – BLEEDING DISORDERS FORM

MUST BE COMPLETED BY HEALTH CARE PROVIDER

Signature of Provider ___________________________ Print Name ___________________________ Date ___________________________

Camper’s Name ___________________________ D.O.B. ___________________________

Type of bleeding disorder: _______ Hemophilia _______ von Willebrand Disease _______ Other

HEMOPHILIA:
(If the child has von Willebrand disease please complete the other side of this form)

What type? □ A / factor VIII □ B / Factor IX □ Other ___________________________

What is the severity? □ Mild □ Moderate □ Severe Factor level ___________________________

History of inhibitors? □ Yes □ No Details: ___________________________________________

Target or restricted joints: ___________________________________________________________________

Treatment:

What brand of factor is used? _____________________________________________________________

Can any other brand be used? □ Yes □ No If yes please specify ___________________________________

Is the child on prophylactic factor replacement? □ Yes □ No

FACTOR THERAPY - Required

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
<td>Prophylactic Therapy</td>
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<tr>
<td>Minor bleeds</td>
<td></td>
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<tr>
<td>Joint bleeds</td>
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<tr>
<td>Major bleeds</td>
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<tr>
<td>Trauma or Head Injury</td>
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</tbody>
</table>

Does the child self-infuse? □ Yes □ Yes, with assistance □ No □ No, but would like to learn

Does the child receive any other treatment such as Stimate of Amicar? □ Yes □ No

Please provide dose and instructions:

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
<th>Dose</th>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
<td>Amicar</td>
<td></td>
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<tr>
<td>Stimate</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

Activity Permission:

Can the child participate in horseback riding? □ Yes, without pretreatment □ Yes, with pretreatment □ No

Can the child participate in a low ropes adventure course? □ Yes, without pretreatment □ Yes, with pretreatment □ No

Can the child participate in a high ropes adventure program (climbing wall and zip line with harness safety system)? □ Yes, without pretreatment □ Yes, with pretreatment □ No

FAX COMPLETED FORM TO (860) 429-7295
THE HOLE IN THE WALL GANG CAMP - FAMILY CAMP

PART III – BLEEDING DISORDERS FORM

VON WILLEBRAND DISEASE

Camper’s Name ____________________________________ D.O.B. ____________________________

What type of vWD does the child have? □ Type 1 □ Type 2 □ Type 2B □ Type 2N □ Type 3

How often does the child have problems with bleeding?

□ Rarely (< once a month)          □ Often (once a week)
□ Occasionally (> once a month, < once a week) □ Frequently (> once a week)

Please describe the type and severity of the child’s bleeding episodes: ______________________________
________________________________________________________________________________________
________________________________________________________________________________________

Treatment:

What treatment does the child require? □ DDAVP / Stimate □ Amicar □ Factor Infusion □ Other

How often does the child require treatment?

□ Rarely (< once a month)          □ Often (once a week)
□ Occasionally (> once a month, < once a week) □ Frequently (> once a week)

Please provide medications, doses, and frequency

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
<th>Dose</th>
<th>Frequency</th>
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</tbody>
</table>

Has the child had Emergency Room visits and/or hospitalizations due to bleeding? □ Yes □ No
If yes, please describe ________________________________________________________________
________________________________________________________________________________________

Activity Permission:

Can the child participate in horseback riding? □ Yes, without pretreatment □ Yes, with pretreatment □ No

Can the child participate in a low ropes adventure course? □ Yes, without pretreatment
□ Yes, with pretreatment □ No

Can the child participate in a high ropes adventure program (climbing wall and zip line with harness safety system)?
□ Yes, without pretreatment □ Yes, with pretreatment □ No

Additional Information:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

FAX COMPLETED FORM TO (860) 429-7295
PART III – METABOLIC/MITOCHONDRIAL FORM

MUST BE COMPLETED BY HEALTH CARE PROVIDER

Signature of Provider ____________________________ Print Name ____________________________ Date ________________

Camper’s Name ____________________________ D.O.B. ____________________________

Diagnosis: ____________________________ Date of Diagnosis: ____________________________

ACTIVITY LEVEL

What is the child’s typical activity level? ____________________________ How much time does he/she spend outside? ____________________________

DIET/FLUIDS

How much fluid does the child need in a day? ____________________________

Does the child need their blood sugar checked? □ Yes □ No If yes, how often and at what times of the day? ____________________________

What dietary restrictions/requirements does the child have? ____________________________

MEDICAL EMERGENCIES - please attach a copy of the child’s emergency protocol

What are the early signs that the child is decompensating? ____________________________

What should treatment be provided? ____________________________

What are the signs that their illness is progressing and that more aggressive treatment is needed? ____________________________

What should treatment be provided? ____________________________

When does the child need to go to the hospital? ____________________________

FAX COMPLETED FORM TO (860) 429-7295
THE HOLE IN THE WALL GANG CAMP - FAMILY CAMP

PART III – IMMUNOLOGY FORM

MUST BE COMPLETED BY HEALTH CARE PROVIDER

_____________________________     ___________________________     ___________________________
Signature of Provider    Print Name    Date

Camper’s Name ____________________________    D.O.B. ____________________________

Diagnosis: ____________________________    Date of Diagnosis: ____________________________

ACQUIRED IMMUNODEFICIENCY:

□ Yes □ No    Details: ____________________________

Is child aware of his or her diagnosis? □ Yes □ No

□ Yes □ No    Details: ____________________________

Is child compliant with medications?

□ Yes □ No    Details: ____________________________

Most recent or typical blood counts:

Date ____________________________

Hb _________    Hct _________    WBC _________    ANC _________    Plt _________

CD4+ Cell Count/% ____________________________    Viral Load Copy ____________________________

Other _____________________________________________________________________________

Additional Comments:______________________________________________________________________________

CONGENITAL IMMUNODEFICIENCY:

Please describe any infectious issues the child has: ____________________________

_________________________________________________________________________________________

Does this child receive immunoglobulin replacement? □ Yes □ No

□ Yes □ No    If yes, what product ____________________________

Schedule: ____________________________

Has the child ever had a reaction to immunoglobulin? □ Yes □ No

□ Yes □ No    If yes, please explain ____________________________

Does the child have a scheduled protocol or work up in the event of fever? □ Yes □ No

□ Yes □ No    If yes, please explain, or attach a copy of the protocol ____________________________

Additional Comments:______________________________________________________________________________

______________________________________

___________________________________________________

FAX COMPLETED FORM TO (860) 429-7295
PART III – OTHER DIAGNOSIS FORM

MUST BE COMPLETED BY HEALTH CARE PROVIDER

Signature of Provider ____________________________ Print Name ____________________________ Date ____________________________

Camper’s Name ____________________________ D.O.B. ____________________________

Diagnosis: ____________________________ Date of Diagnosis: ____________________________

Is this child currently receiving treatment? □ Yes □ No If yes, please explain ____________________________

___________________________________________________________________________________

___________________________________________________________________________________

How is the child affected by the diagnosis?

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Does the child have any other medical problems? □ Yes □ No If yes, please explain ____________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Does the child have dietary restrictions or allergies? □ Yes □ No If yes, please explain ____________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Most recent or typical blood counts: Date ____________________________

Hb ______  Hct ______  WBC ______  ANC ______  Plt ______

Other _______________________________________________________________________

Additional Comments: _______________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

FAX COMPLETED FORM TO (860) 429-7295
CV CATHETER FORM

Complete this form only if the child has a central line (Broviac, Hickman, Portacath, etc.)

TO BE COMPLETED BY HEALTH CARE PROVIDER

All necessary supplies (dressing kits, heparin, syringes, access needles, numbing spray or cream, etc.) must be sent to Camp with child. Children will need 7 dressing kits (or equivalent supplies for the week) if they plan on swimming every day.

Camper Name: ___________________________ Birthdate: ___________________ Date: ________________

Type of catheter: (External) Broviac/Hickman _____
                  Single lumen _____  Double lumen _____

                  (Internal) Portacath/ Infusaport _____

                  Other ________________________________________________

Specific Instructions for catheter care:

How often is it flushed with heparin? ________________________________

What amount & strength of heparin is used? ____________________________

What size needle is used for access? _______ gauge _______ length

What kind of numbing cream or spray is used? _________________________

How often is the dressing changed? _________________________________

When is the cap changed? (day of the week) _________________________

Does this child do any or all of their own catheter care? □ Yes □ No

If Yes, please explain __________________________________________________________________

_________________________________________________________________________________

May this line be used to draw blood? □ Yes □ No

What, if any, medications are to be infused into this line during the Camp period?
_________________________________________________________________________________

_________________________________________________________________________________

Special instructions: ____________________________________________________________

_________________________________________________________________________________

CENTRAL LINE CONSENT - Unless otherwise specified, all children will be permitted to swim.

This child: □ DOES □ DOES NOT have permission to go swimming in a chlorine-treated swimming pool. (Dressings will be changed immediately following swimming)

_____________________________ ___________________________
Physician’s Signature Date

FAX COMPLETED FORM TO (860) 429-7295
THE HOLE IN THE WALL GANG CAMP - FAMILY CAMP

INFUSION PUMP FORM
Complete this form only if the child uses a desferal infusion pump, TPN pump, gastrostomy feeding pump, etc

TO BE COMPLETED BY HEALTH CARE PROVIDER

You must send all supplies including medication, sterile water, needles, syringes, batteries to camp.

Camper Name: ____________________________ Birthdate: ________________ Date: ________________

Manufacturer and model of pump ____________________________

Contact number for service or replacement ____________________________

Instructions for medication infusion pumps

Medication:________________________________________________________

Dose:___________________________________________________________

Mixing Instructions (Diluent Amount):________________________________

Length and rate of infusion:________________________________________

Frequency of infusion while at Camp. Days of week?____________________

Instructions for g-tube feeds or TPN

Continuous feeds/TPN:

Product and Quantity:______________________________________________

Infusion rate:_____________________________________________________

Infusion times:____________________________________________________

Bolus Feeds:

Product and Quantity:______________________________________________

When is it given?__________________________________________________

How is it given? (pump, gravity, push):________________________________

Additional Information:______________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

FAX COMPLETED FORM TO (860) 429-7295