



Double H Ranch

A SeriousFun Camp

97 Hidden Valley Road Lake Luzerne, NY 12846

Phone:(518) 696-5676 Fax:(518) 696-9927

For Office use only

APPROVED for camp: Yes No

Conditional on _____

Signature _____ Date ____ / ____

2018 Weekend Application

Please select the weekend you plan on attending:

- Hematology / Oncology Weekend
- Camp Inspiration
- Bravehearts Weekend
- Family Memorial Weekend
- Cindy's Comfort Camp
- Mitochondrial / Collagen Vascular / Journey's Weekend
- Diabetes Family Weekend
- Spina Bifida Weekend

Members Attending

Parent / Guardian / Adult Name _____ Relationship to camper _____

Parent / Guardian / Adult Name _____ Relationship to camper _____

Child's Name _____ Age _____ Boy Girl

Child's Name _____ Age _____ Boy Girl

Child's Name _____ Age _____ Boy Girl

Child's Name _____ Age _____ Boy Girl

Who in your family has the condition that we are serving? _____

Please explain any special needs your family may have: Special housing request _____

Wheelchair accessibility Shared medication fridge Dietary Needs _____

Family Contact Information

Address _____

City _____ State _____ Zip _____ County _____

Home phone# (____) _____ Cell phone# (____) _____ Work phone# (____) _____

E-mail address _____

Emergency Contact Information (must be >18 yrs old and NOT coming to camp)

Emergency Contact Name _____ Relationship _____

Home phone# (____) _____ Cell phone# (____) _____



Camper Name _____ DOB _____

Each camper must complete this form EVERY YEAR. If needed, please may make additional copies.

Camper General History 2018

- ★ Does participant have any **drug allergies**?
 YES NO If yes, to what drug and what reactions _____
- ★ Does participant have any **food restrictions, food allergies or environmental allergies**?
 YES NO If yes, please explain _____
- ★ Does participant have any **past or on going medical problems** (such as asthma, developmental delay, hearing or vision loss)?
 YES NO If yes, please explain _____
- ★ Does participant have past **hospitalizations or surgery** (Please give year and nature of medical problem)?
 YES NO If yes, please explain _____
- ★ Is the participant currently on any **medications**?
 YES NO If yes, please list _____
- ★ Does participant have a **activity restrictions**?
 YES NO If yes, please explain _____
- ★ Does participant have any **physical limitations / mobility devices**? Wheelchair Power wheelchair crutches walker AFO's
 YES NO If yes, please explain _____
- ★ Does participant have **seizures**?
 YES NO If yes, please describe _____ When was the last seizure? _____
How frequent are the seizures? _____ Is any treatment needed? _____
- ★ Does camper have a **sleep apnea monitor, other monitoring devices**, or is your child on CPAP or BiPAP?
 YES NO If yes, please explain _____
**Please note campers on BiPAP can only attend Camp Inspiration, we have specific criteria for a limited number of campers on CPAP during general sessions.*
- ★ ★ What is participants means of **communication**?
VERBAL NON-VERBAL USES SIGN LANGUAGE USES ASL USES ELECTRONIC DEVICE (please bring to camp)
- ★ ★ Camp is designed for children who function at a 6-16 year old level. At **what developmental age does participant function?**
1-3 yrs old 4-5 yrs old 6-8 yrs old 9-10 yrs old 11-12 yrs old 13-14 yrs old 15-16 yrs old 17 - 21 yrs old

Camper Name _____ DOB _____

Camper Behavior Information 2018

Please help us to understand your child by answering the following questions:

★ Please describe your child's personality. Include their strengths and how they handle frustration: _____

★ What is the best approach to instruct your child? _____

★ Has your child ever been diagnosed with:

ADD / ADHD Conduct Disorder Depression Other _____
 Autism Spectrum Disorder (PDD, Asperger's Syndrome) Eating Disorder Bipolar Disorder

Mandatory Permissions 2018

Please read the following descriptions carefully and grant permission for you and / or your children to participate in each individual activity.
*** Please note not all activities may be applicable to your program.

★ May the participant participate in a supervised, structured **swimming or boating program**? YES NO

★ I do do not give the **Double H Ranch permission to photograph and/or videotape my child**, and to use my child's name, likeness, image, and/or video in promotional materials, including fundraising, marketing, and educational materials. I understand that my child's name, likeness, image, and/or video may be used to promote public understanding and support of programs for children with critical illnesses, and that the materials containing my child's name, likeness, image, and/or video may be used in the current year and/ or in future years. This consent may be revoked in writing at any time, except to the extent that the Double H Ranch has already relied upon it in making use of my child's name, likeness, image, and/or video. I understand that this consent is not a condition of participation in the program.

★ Our high ropes program offers a safe and adventurous opportunity and is supervised by professionally trained program staff. All participants wear the safety equipment provided, including helmets and harnesses, which protects them from falls.

YES NO **May your child participate in a supervised high ropes course program with certified staff?**

★ Our archery program focuses on safety and skill development. Archery is facilitated by trained staff who practice all standard safety archery regulations. All children wear arm guards which protects them from injury.

YES NO **May your child participate in a supervised archery program?**

Mandatory Signature (Parent/Guardian/Participant)

Date

Camper Name _____ DOB _____

Camper Physical Exam Form Page 1 2018

Today's Date ____ / ____ / ____ Date PE based on ____ / ____ / ____

**If child has been hospitalized or had surgery in the last 12 months, please provide a copy of the discharge summary.*

Primary Diagnosis: _____ Date of Dx ____ / ____ / ____

Secondary Diagnosis/Problems: _____

List Surgeries: _____

If Cancer, is child still on Chemotherapy? YES NO When was chemo completed? ____ / ____ / ____

Allergies: Drug _____ Food or other Allergies _____

Does child have any of the following:

- Central access If YES, Type: _____ Location: _____ *Please submit **CVL Form**
 Trache On O2 CPAP/BiPAP Shunt G Tube/J Tube Baclofen Pump Mitrofanoff Malone ACE

Vital Signs: Ht _____ in / cm Wt _____ lb / kg BP _____ HR _____ RR _____

Has child had any infections with resistant organisms? YES NO if yes, please explain: _____

Checklist Mandatory: Check If Normal, or give details of **abnormalities** below.

HEENTN: _____

Respiratory: _____

Cardiovascular: _____

Gastrointestinal / Renal: _____

Musculoskeletal: _____

Neurological: _____

Skin: _____

Genitalia & Rectum: _____

Seizures: YES NO if YES, **Frequency** _____ **Type** _____

Treatment: _____

Behavioral Issues: AD(H)D Oppositional Eating Disorder Other _____

Comments: _____



Camper Name _____ DOB _____

Camper Physical Exam Form Page 2 2018

MEDICATIONS

Each family should send all medications and medical supplies necessary for their child while at camp. The medical staff will store and administer medications as directed by you.

***Please note: Standard Med Times are Breakfast, Lunch, Dinner, Bedtime.**

Is camper on any Clinical Trial Medications? YES NO *If yes, we will contact you for additional information.*

Medication Name	Dose	Route	Frequency / Time

Please include information about medications used to prevent nausea and vomiting and **pain management** if applicable.

Additional Comments / limitations? _____

Physician's Statement: I have examined _____ who is physically able to engage in all camp activities; including our Adaptive Winter Sports Program and rides at the Great Escape Park except for physical limitations and restrictions previously stated. I agree with continuing the above medical regimen while at camp. **For detailed information about camp activities, please see our Physician Information Sheet available on our website or through our Admissions Department.**

MANDATORY Signature of Physician _____ **PRINTED Name** _____

Institution _____ **Email** _____

Address _____

City _____ **State** _____ **Zip** _____

Phone # (_____) _____ **After hours phone #** (_____) _____ **Fax #** (_____) _____



Camper Name _____ DOB _____

Camper Immunizations

Participants **Will NOT be accepted** without dates indicating immunizations are current (unless contraindicated).

<p>Chicken Pox 2 doses REQUIRED unless contraindicated</p> <p><input type="radio"/> Clinical Disease Date _____ (Diagnosed by MD)</p> <p><input type="radio"/> Varivax Vaccines Dates _____ (2 doses)</p> <p><input type="radio"/> Positive Titer Date _____</p> <p><input type="radio"/> Camper is NOT IMMUNE and the vaccine is contraindicated Reason contraindicated _____</p>	<p>Tetanus and Pertussis 6-10 years old Must have had a least 4 DTaP with the last dose at age 4 or older.</p> <p>4 doses total of DTaP <input type="radio"/> YES <input type="radio"/> NO</p> <p>Date of last DTaP _____</p> <p>11-21 years old must have at least 5 doses with a Tdap booster at age 10 or older and not more then 9.5 yrs pre camp.</p> <p>5 doses total <input type="radio"/> YES <input type="radio"/> NO</p> <p>Date of last Tdap _____</p>
<p>Polio Campers must have completed polio vaccines; 3-4 doses</p> <p>Is this series complete? <input type="radio"/> YES <input type="radio"/> NO</p>	
<p>Meningitis Required for 11 years old Booster required 5 years after first dose Must be (Menactra®, Menveo®, MCV4)</p> <p>Type _____ Date _____</p> <p>Type _____ Date _____</p>	
<p>MMR 2 doses REQUIRED unless contraindicated</p> <p>MMR 1 Date _____</p> <p>MMR 2 Date _____</p> <p>Positive Titer Date _____</p>	<p>Recommended We strongly recommend the following vaccines .</p> <p>HIB (Hemophilus) immunized? <input type="radio"/> YES <input type="radio"/> NO</p> <p>Pneumococcal vaccine Date(s) _____</p> <p><input type="radio"/> Prevnar (PCV7 or13) <input type="radio"/> Pneumovax</p> <p>Hep B vaccine Date(s) _____</p> <p>Hep A vaccine Date(s) _____</p>

Sibling Name _____ DOB _____

Each sibling must complete this form EVERY YEAR. If needed, please may make additional copies.

Sibling General History 2018

- ★ Does sibling have any **drug allergies**?
 YES NO If yes, to what drug and what reactions _____
- ★ Does sibling have any **food restrictions, food allergies or environmental allergies**?
 YES NO If yes, please explain _____
- ★ Does sibling have any **past or on going medical problems** (such as asthma, developmental delay, hearing or vision loss)?
 YES NO If yes, please explain _____
- ★ Does sibling have past **hospitalizations or surgery** (Please give year and nature of medical problem)?
 YES NO If yes, please explain _____
- ★ Is the sibling currently on any **medications**?
 YES NO If yes, please list _____
- ★ Does sibling have any **activity restrictions**?
 YES NO If yes, please explain _____
- ★ Does sibling have any **physical limitations / mobility devices**? Wheelchair Power wheelchair crutches walker AFO's
 YES NO If yes, please explain _____
- ★ Does sibling have **seizures**? YES NO If yes, please describe _____ When was the last seizure? _____
How frequent are the seizures? _____ Is any treatment needed? _____
- ★ Does sibling have a **sleep apnea monitor** or any other **monitoring devices**?
 YES NO If yes, please explain _____
- ★ ★ What is siblings means of **communication**?
VERBAL NON-VERBAL USES SIGN LANGUAGE USES ASL USES ELECTRONIC DEVICE (*please bring to camp*)
- ★ ★ Camp activities are designed for children 6-16 years old. At **what age does sibling function**?
1-3 yrs old 4-5 yrs old 6-8 yrs old 9-10 yrs old 11-12 yrs old 13-14 yrs old 15-16 yrs old 17 - 21 yrs old

Sibling Immunization 2018 (complete for ages 5 - 21)

Chicken Pox

Immunity is **REQUIRED** unless contraindicated. Sibling is immune to Chicken Pox by one of the following:

- Clinical Disease Date _____ (Diagnosed by MD)
- Varivax Vaccines Dates _____ (2 doses required)
- Positive Titer Date _____

MMR REQUIRED

Siblings must have **MMR x 2**

MMR 1 Date _____
MMR 2 Date _____
Positive Titer Date _____

Seasonal Flu

Recommended every year for siblings. Please discuss with your primary physician to determine if one or two shots are required.

Seasonal Flu Date _____



Sibling Name _____ DOB _____

Sibling Behavior Information 2018

Please help us to understand your child by answering the following questions:

★ Please describe your child's personality. Include their strengths and how they handle frustration: _____

★ What is the best approach to instruct your child? _____

★ Has your child ever been diagnosed with:

ADD / ADHD Conduct Disorder Depression Other _____

Autism Spectrum Disorder (PDD, Asperger's Syndrome) Eating Disorder Bipolar Disorder

Mandatory Permissions 2018

Please read the following descriptions carefully and grant permission your child to participate in each individual activity.
*** Please note not all activities may be applicable to your program.

★ May your child participate in a supervised, structured **swimming or boating program**? YES NO

★ I do do not **give the Double H Ranch permission to photograph and/or videotape my child**, and to use my child's name, likeness, image, and/or video in promotional materials, including fundraising, marketing, and educational materials. I understand that my child's name, likeness, image, and/or video may be used to promote public understanding and support of programs for children with critical illnesses, and that the materials containing my child's name, likeness, image, and/or video may be used in the current year and/or in future years. This consent may be revoked in writing at any time, except to the extent that the Double H Ranch has already relied upon it in making use of my child's name, likeness, image, and/or video. I understand that this consent is not a condition of participation in the program.

★ Our high ropes program offers a safe and adventurous opportunity and is supervised by professionally trained program staff. All participants wear the safety equipment provided, including helmets and harnesses, which protects them from falls.

YES NO **May your child participate in a supervised high ropes course program with certified staff?**

★ Our archery program focuses on safety and skill development. Archery is facilitated by trained staff who practice all standard safety archery regulations. All children wear arm guards which protects them from injury.

YES NO **May your child participate in a supervised archery program?**

Mandatory Signature (Parent/Guardian/Participant)

Date

Family Member Name _____ DOB ____ / ____ / ____

Parent / Guardian Medical Information 2018

TO BE COMPLETED BY THE PARENT or GUARDIAN: (We need this form EVERY year)

★ 1. Do you have any **drug allergies**?

YES NO If yes, to what drug and what reactions _____

★ 2. Do you have any **food restrictions, food allergies** (e.g. peanuts, milk) or special diet requirements?

YES NO If yes, please explain _____

★ 3. Do you have a **past or on-going medical history** (such as asthma, diabetes, heart disease, etc.)?

YES NO If yes, please explain _____

★ 4. Do you have past **hospitalizations or surgery** (Please give year and nature of medical problem)?

YES NO If yes, please explain _____

★ 5. Are you currently on any **medications**?

YES NO If yes, please list _____

★ 6. Do you have any **activity restrictions**?

YES NO If yes, please list _____

Mandatory Permissions 2018

Please read the following descriptions carefully and grant permission for you to participate in each individual activity.

***** Please note not all activities may be applicable to your program.**

★ 1. May you participate in a supervised, structured **swimming or boating program**? YES NO

★ 2. I do do not give the **Double H Ranch permission to photograph and/or videotape myself**, and to use my name, likeness, image, and/or video in promotional materials, including fundraising, marketing, and educational materials. I understand that my name, likeness, image, and/or video may be used to promote public understanding and support of programs for children with critical illnesses, and that the materials containing my name, likeness, image, and/or video may be used in the current year and/or in future years. This consent may be revoked in writing at any time, except to the extent that the Double H Ranch has already relied upon it in making use of my name, likeness, image, and/or video. I understand that this consent is not a condition of participation in the program.

★ 3. Our high ropes program offers a safe and adventurous opportunity and is supervised by professionally trained program staff. All participants wear the safety equipment provided, including helmets and harnesses, which protects them from falls.

YES NO **May you participate in a supervised high ropes course program with certified staff?**

★ 4. Our archery program focuses on safety and skill development. Archery is facilitated by trained staff who practice all standard safety archery regulations. All participants wear arm guards which protects them from injury.

YES NO **May you participate in a supervised archery program?**

Mandatory Signature (Parent/Guardian/Participant)

Date

