



SIBLING APPLICATION

Date Received: _____
(for office use only)

Please complete the entire application and return it to our foundation office. This is a cost-free camp for children who have a brother, sister or parent with cancer. Transportation arrangements and expenses are the responsibility of the participant and his/her family. Please call (406) 549-5987 with questions. Please send completed application to address / fax number / e-mail listed below.

Participant Name: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Date of Birth: ____/____/____ Male Female

CAMP SESSION (See Program Schedule at www.campdream.org for list of sessions, dates and ages)

Date of camp session participant is applying for: _____

Has participant been to Camp Mak-A-Dream before? Yes No If yes, number of times: _____

How did you hear about Camp? Internet Another Participant Medical Center Other _____

Name of Cancer Patient: _____ Relationship to Participant: _____

Name of Parent/Guardian: _____ Relationship to Participant: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____ E-mail address: _____

EMERGENCY CONTACT (if above cannot be reached) Name: _____

Relationship to Participant: _____ Daytime Phone: (_____) _____

Evening Phone: (_____) _____ Cell Phone: (_____) _____

INSURANCE INFORMATION (Please include a copy of participant's insurance card with application.)

To be used for special tests, treatments, X-Rays or medical consultations in the event any are needed.

Name of Insurance Company: _____

Name of parent who insures child: _____

Address: _____ City: _____ State: _____

Phone: (_____) _____ Policy Number: _____

If Group insurance, company name: _____ Group # : _____

If Medicaid, indicate number: _____ *(form continued on next page)*

SIBLING CAMP APPLICATION

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CONSENT AGREEMENT, AUTHORIZATION AND RELEASE

This Consent agreement, Authorization and Release must be read and signed for the participant to be eligible to attend Camp Mak-A-Dream. For participants under the age of 18, form must be completed and signed by a parent or legal guardian. Participant's full name (printed): _____

RELEASE OF LIABILITY

The undersigned understands that occasionally accidents occur during camp activities and that participants may sustain serious personal injury and property damages as a consequence thereof. Knowing the risks of camp activities, nevertheless, and in consideration of the participant's acceptance for participation at camp, the undersigned hereby agrees to assume those risks and to hold harmless the Children's Oncology Camp Foundation, and all camp agents, representatives, employees, and volunteers, from any and all liability, claims for personal injury and/or property damage, costs, expenses, and damages arising out of or connected in any way with the participant's participation in camp activities. Further, the undersigned acknowledges that Camp Mak-A-Dream accepts no responsibility for the loss, damage, or theft of personal property.

CONSENT FOR MEDICAL TREATMENT

The undersigned hereby grants permission to the medical staff or consulting physicians at Camp Mak-A-Dream to administer medication and provide medical care, including any medical emergency care required, and any emergency transportation deemed necessary.

PHOTO AND INFORMATION RELEASE

The undersigned gives Camp Mak-A-Dream permission to photograph and use pictures or visual and audio recordings of the participant in professional and fundraising and/or marketing activities. On occasion, with this permission, participant photographs may be included in a bulletin board, video, website, newsletter, camp album, or in personal photographs. The camp respects the privacy of its participants and does not allow unauthorized visitors to photograph the camp or participants.

In addition, by signing below, the undersigned gives Camp Mak-A-Dream the permission to give the participant's contact information to groups or individuals wishing to support Camp Mak-A-Dream by sending them an invitation to an event or by sending information related to camp. This **will not** be a list sold or given to anyone else for any other reason.

PARTICIPATION CONSENT

The undersigned gives permission for the participant to participate in any and all activities, including transportation to and from camp for camp activities, except those specifically prohibited by participants' physician or parent/guardian listed below.

X _____
Parent or Guardian Signature

Date



SIBLING PHYSICAL EXAM FORM

Participant Name: _____

A Parent/Guardian should complete the top portion of this form and the participant's physician the lower half.

SHARING OF MEDICAL INFORMATION

I give permission for my child's physician(s) to provide medical information directly to Camp Mak-A-Dream.

X _____
Signature of Parent / Guardian Date

SIBLING'S EXAMINATION RECORD Health History (please check all that apply):

- | | | |
|---|---|---|
| <u>Disease</u> | <u>Allergies</u> | <u>Chronic or Recurring Illness</u> |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Drugs | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Diabetes |
| | <input type="checkbox"/> Ivy, Oak, etc. | <input type="checkbox"/> Behavior |
| | <input type="checkbox"/> Foods: _____ | |

Participant's immunizations are current: Yes No If no, explain: _____

Operations or serious injuries (dates): _____

Hospitalizations: _____

Other diseases or details of above: _____

Please make any necessary comments regarding the following:

- | | |
|--------------------|--------------------------|
| Fainting _____ | Sleep Disturbances _____ |
| Bed Wetting _____ | Menstruation _____ |
| Constipation _____ | Other _____ |

Specific activities to be restricted (if any): _____

Special medical or dietary regimen to be followed (specify): _____

PHYSICAL EXAMINATION *(the section below is to be filled out & sent in by participant's physician)*

Physical exams must be completed within six months of camper's attendance of camp.

Name of Physician: _____ Medical Center / Clinic: _____

Date of Examination: _____ Height: _____ Weight: _____ BP: _____

Appearance/Nutrition: Code: Satisfactory (/) Not Satisfactory (x) Not Examined (o)

- | | | |
|------------------------------|-----------------|-----------------------|
| Ears - Hearing (right) _____ | (left) _____ | Musculoskeletal _____ |
| Nose _____ | Abdomen _____ | Teeth _____ |
| Throat _____ | Genitalia _____ | Hernia _____ |
| Heart _____ | Skin _____ | Lungs _____ |

X _____
Physician Signature Date