



SIBLING APPLICATION CAMP MAK-A-DREAM

Date Received: _____

Please complete the entire application and return it to our foundation offices as soon as possible. This is a cost-free camp for children ages 6-16 who have a brother or sister with cancer. Transportation arrangements and expenses are the responsibility of the participant and his/her family. You may call (406) 549-5987 with any additional questions. Please send completed application to:

Camp Mak-A-Dream
P.O. Box 1450
Missoula, MT 59806.

Camper's Name: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: () _____ Grade in Fall: _____ Male Female
Social Security Number: _____

Name of Cancer Patient: _____ Relationship to Camper: _____
Name of Parent/Guardian: _____ Relationship to Camper: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: () _____ Work Phone: () _____
Emergency Contact (if above cannot be reached): _____
Relationship to Camper: _____ Phone: () _____

INSURANCE INFORMATION

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

If Medicaid, indicate number: _____
Name of Insurance Company: _____
Address: _____ Phone: () _____
Policy Number: _____
If group insurance, specify company: _____
Name of parent who insures child: _____
Any specific billing instructions: _____

CONSENT FOR EMERGENCY & OUTPATIENT TREATMENT

This child has been left temporarily in the care and custody of Children's Oncology Foundation/Camp Mak-A-Dream. The undersigned parent/guardian hereby grants permission to the medical staff or consulting physicians at Camp Mak-A-Dream to administer medication and provide medical care for my child, including any medical emergency care required. I also give my consent for any emergency transportation deemed necessary.

PHOTO AND INFORMATION RELEASE

I give Camp Mak-A-Dream permission to photograph and use pictures or visual and audio tapes of my child in professional and fund raising activities. The philosophy of Camp Mak-A-Dream is to photograph children infrequently. On occasion, with this permission, camper photographs may be included in a bulletin board, video, newsletter, camp album, or in personal photographs. The camp respects the privacy of its campers and does not allow unauthorized visitors to photograph the camp or campers.

In addition, by signing below, I give Camp Mak-A-Dream the permission to give my child's name, address, and/or phone number to groups or individuals wishing to support Camp Mak-A-Dream by inviting my child to an event or by sending my child information related to camp. This **will not** be a list sold or given to anyone else for any other reason.

RELEASE OF LIABILITY

The undersigned parent/guardian 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 my child'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 my child's participation in camp activities. Further, the undersigned acknowledges that Camp Mak-A-Dream accepts no responsibility for the loss, damage, or theft of my child's personal property.

X _____
Parent or Guardian Signature

Date

X _____
Signature of Witness

Date

SIBLING'S CAMP STANDARD HEALTH EXAMINATION RECORD

Health History (please check):

Disease

- Chicken Pox
- Measles
- German Measles
- Mumps

Allergies

- Hay Fever
- Asthma
- Drugs
- Insect Stings
- Ivy, Oak, Etc.
- Foods

Chronic or Recurring Illness

- Ear Infections
- Heart Disease
- Convulsions
- Diabetes
- Behavior

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

Please have your child's physician fill out this section completely before mailing back to Camp Mak-A-Dream. It is required that all participants have physical exams within six months of attending camp.

Date of Examination: _____ Name of Physician: _____

Height: _____	Weight: _____	BP _____	Code: Satisfactory /
Appearance/Nutrition: _____			Not Satisfactory x
Ears _____	Hearing (right) _____	(left) _____	Not Examined o

Nose _____	Abdomen _____
Throat _____	Genitalia _____
Teeth _____	Hernia _____
Heart _____	Skin _____
Lungs _____	Musculoskeletal _____

IMPORTANT! PLEASE INCLUDE A COPY OF THIS CHILD'S IMMUNIZATION RECORDS FOR THIS FORM.

X _____
 Physician's Signature

 Date