Stanford Children's Health | Lucile Packard Children's Hospital Stanford

April 5, 2018

Dear Parents and Campers,

We are pleased to announce that Lucile Packard Children's Hospital Stanford (LPCH) will again be partnering with St. Dorothy's to offer Transplant Camp. St. Dorothy's is located at Camp Meeker, California and has been sponsoring camps for children with special health needs since 1983. This year, the camp will take place **Monday July 23 – Saturday July 28, 2018**. The camp will include children with solid organ transplants ages 8 through 18. Camp activities will vary depending on the age of the child.

Nurses and a Child Life specialist from LPCH will be available continuously throughout camp to ensure that campers receive their medications, water, and any necessary medical attention. There is no charge for camp. Round trip bus transportation from LPCH to St. Dorothy's will be provided.

If you wish to enroll in camp, please fill out the enclosed application packet and mail, email or fax it back to Kirsten Cotten ,no later than **May 31st, 2018**. Space at camp is limited to the first 60 campers. After your application is received, it will be reviewed and if appropriate, you will be placed on the camp list. Once the camp is full, your name will be placed on a wait list.

A doctor's visit and clearance is required, within 6 weeks prior to attending camp. This can be done by either your Primary Care Provider (PCP) or your transplant team MD/NP/PA.

In mid-June an additional packet will be mailed to all campers with more specific camp information (i.e., medical provider form, bus schedule, packing list, etc.). Please contact Kirsten Cotten in the Child Life Department or your social worker if you have any questions about camp or the application process. We hope to see you in July!

Sincerely,

The Camp Committee

Contact Information for:
Kirsten Cotten CCLS, CTRS
725 Welch Road
Palo Alto CA, 94304
Phone number: (650) 497-8336
Kcotten@stanfordchildrens.org

LPCH TRANSPLANT CAMP APPLICATION
CAMP ST. DOROTHY'S
July 23-28, 2018

CAMPER INFORMATION

Camper's Full Name:_____
Age at camp:_____ Birthdate:_____ Male/Female: _____
Type of Transplant:_____Transplant Date:_____
Reason for Transplant:_____
Recent hospitalizations, illnesses and/or Procedures:_____
_____
_____

Parent/Guardian:_____
Street Address: _____
City:_____State:_____Zip Code:_____
Home Phone:_____Cell Phone:_____
Work Phone:_____Other Phone:_____
Email:_____
With whom does the child live? _____
If parents are divorced, who has legal custody?_____

EMERGENCY CONTACTS: please list 2 adults (other than the child's parent or guardian) who, in case of an emergency, LPCH staff or the camp may contact or turn your child over to if you are not available. Please ensure contacts are aware of camp name and session dates.

Name: Relationship:
Phone Numbers:

Name: Relationship:
Phone Numbers:

HEALTHCARE PROVIDER

Transplant Physician (nephrologist, cardiologist, hepatologist):_____
Transplant Nurse Coordinator:_____
Phone #:_____

Pediatrician/Primary MD:_____
Phone #:_____

INSURANCE INFORMATION

Insurance Carrier:_____
Policy #:_____
Member Name: _____

**** PLEASE INCLUDE A COPY OF YOUR CHILD'S INSURANCE CARD (both sides) AND PRESCRIPTION CARDS WITH APPLICATION *****

PARENT/GUARDIAN MEDICAL AUTHORIZATION

I hereby give my permission to the physician selected by the Director of St. Dorothy's Rest to order x-rays, routine tests and treatment for the health of my child and in the event where I cannot be reached in an emergency, I give permission to the physician selected by the Director of St. Dorothy's Rest to hospitalize, secure treatment for and to order injections, medications and/or anesthesia and/or surgery for my child as named below. I understand that this is not a medical camp and Lucile Packard Children's Hospital Stanford does not assume any medical care or responsibility while your child is at camp.

Child / Camper's Name:_____
Signature of Parent/Legal Guardian:_____
Date of signature:_____

THIS PAGE MUST BE COMPLETED AND SIGNED IN ORDER FOR YOUR CHILD TO ATTEND CAMP!!!

GENERAL HEALTH INFORMATION

IMMUNIZATIONS:

Are your child's immunizations up to date? □ Yes □ `No

(We strongly recommend that your child receive the seasonal flu vaccines per your doctor's recommendations.)

Has your child been exposed to the, chicken pox, measles, or any other communicable disease in the past two weeks? □ Yes □ No

If yes, explain:_____

Does your child have any chronic respiratory infections (MRSA, pseudomonas, etc.)? □ Yes □ No

If yes, explain: _____

OTHER MEDICAL CONDITIONS: (check all that apply)

□ Arthritis	□ Headaches	□ Nose Bleeds	□ Constipation
□ Diarrhea	□ Bleeding Disorders	□ Ear Infections	□ Heart Problems
□ Pacemaker	□ Fainting Spells	□ Hypertension	□ Palpitations
□ Diabetes	□ Dizziness	□ Stomach Aches	□ Weakness
□ Hearing Loss	□ Vision Loss	□ Bed Wetting	□ Rash/Eczema
□ Ear Tubes	□Nausea/Vomiting	□ Overnight Tube Feedings	

□ Seizures *(date of last: _____ type: _____ duration: _____)*

□ Asthma *(severity: □ mild □ moderate □ severe Is an inhaler used? □ Yes □ No)*

□ Emotional disorders	□ Behavioral problems	□ Girls: started menses
□ Food Allergies	□ Medication Allergies	□ Seasonal Allergies

□ Fluid minimum per day = _____ □ Fluid maximum per day = _____

Please provide details for any items checked above: _____

_____

_____

_____

DEVICES: (check all that apply)

□ G-tube	□ NG tube	□ Ostomy	□ Hearing Aids	□ Glasses/Contacts
□ Dressing Changes		□ Respiratory Treatments		

** no central lines such as PICCs, Broviacs, etc will be allowed at camp.*

Please provide details for any items checked above: _____

_____

_____

_____

GENERAL HEALTH INFORMATION (cont.)

Is there any other information about your child's health or well being that would assist the camp staff and medical team in caring for your child while at camp?_____

_____

_____

_____

DAILY ACTIVITY PARTICIPATION:

Are there any specific activities to be encouraged? _____

Are there any specific activities to be restricted? *If so, why?*_____

_____

Does your child know how to swim? □ Yes □ No

Has your child ever been away from home? □ Yes □ No

Does your child require assistance with any of the following? □Yes □ No

If yes, explain…

	Needs Reminder	Moderate Assistance	Needs Total Care
Daily Care (dressing, brushing teeth)			
Bathing/Showering			
Meals			
Toileting/Bathroom			

Can your child walk ¼-1 mile unassisted several times a day? □Yes □ No

Does she/he require any of the following?

□Wheelchair □Braces □Crutches □Other_____

BEHAVIORAL/EMOTIONAL CONDITIONS: (check all that apply)

□ NONE □ Anxiety □ ADHD □ Autism □ Bipolar Disorder □ OCD

□ PTSD □ Asperger □ Self Harming □ Ticks/Tourette syndrome

□ Other _____

Please provide details for any items checked above: _____

_____

_____

Has your child been prescribed medication for any of above items? □Yes □ No

Is your child currently taking those medications as prescribed? □Yes □ No

If not, why? _____

CAMPER PROFILE

SLEEP AWAY EXPERIENCE:

□ Little to no sleep-away experience □ Has been away from home for 5 days
□ Has attended another sleep-away camp

YOUR CHILD'S PERSONALITY:

□ Outgoing □ Makes friends easily □ Leader □ Follower □ Mature for age
□ Slow to warm up □ Shy □ Easily Frustrated □ Patient □ Easy going
□ Aggressive □ Assertive □ Extra Sensitive □ Participates well with others
COMMENTS: _____

BEDTIME: (check all that apply)

□ Bedwetting □ Fear of dark □ Sleepwalking □ Nightmares
□ Night Terror □ Snoring □ Talks in sleep □ Difficult waking
□ Difficult falling asleep □ Other_____
COMMENTS: _____

ALLERGIES:

Allergies: □ **Check box if none**				
	Allergy	Reaction	Typical course of treatment	Requires Epi-pen*
To Medication				□Yes □ No
To Food				□Yes □ No
To Other (pollen, bees, latex, etc)				□Yes □ No

***(if your child has an epinephrine pen or "epi pen" please send to camp with your medications)**

Does your child have any dietary restrictions or special dietary needs? □Yes □ No
*If yes, explain (including tube feedings)*_____

_____

Please note that if your child has food allergies, you will need to speak with the camp kitchen staff prior to your child's arrival at camp… further information will follow with your final camp packet

MEDICATION LIST

(Include all over the counter medications as well for stomach aches, headaches, etc)

Please be sure that the strength and name of medication on the pill bottles sent to camp matches what you have listed below… ***do not send pills to camp in the wrong med bottles and do not draw up any liquid medications***.

MEDICATION NAME	STRENGTH OF PILLS OR LIQUID	DOSE	FREQUENCY	REASON FOR MEDICATION

Does your child need food (crackers, bread) or something to drink other than water to take medications?

□ yes □ no *if yes, explain*: _____

_____

REMINDERS

- Medication times at camp have been set at 7am and 7pm. We are aware that these times may be a bit different from your child's typical home routine, but the structure of camp and number of campers prohibits us from following each child's home routine. If your child has medications more often than twice daily, we will accommodate these as needed.

- Please check, re-check and triple check the medications and supplies that you send to camp with your child. Be sure that there is enough for the week of camp **plus a 2 day buffer**. **If your child arrives at the bus drop-off or at camp without sufficient medications, they will not be allowed to come to camp… we do not have an extra supply of medications for your child at camp!!!**

- Send ALL medications in their original bottles, even if you use pill boxes.

- Please complete the attached medication list for your child. We will verify all medications and doses with you when you drop your child off for camp, please be sure to notify us at this time of any changes.

- We will require a doctor's visit to Primary/Pediatrician doctor OR your transplant MD/NP/PA prior to attending camp. You will receive a medical provider form in the final camp packet. This form must to be filled out and signed by your doctor when you are seen by them within 6 weeks prior to camp, clearing you to attend camp. You or your MD must submit the signed medical provider form PRIOR to check-in. **If your child arrives with no medical form completed, he or she will not be allowed to come to camp. Please DO NOT schedule this appointment for your child on the day of check in.**

Thank you for your time and consideration. We strive to provide a safe and fun camp for your child.

Thanks,
The camp committee

Parent/Guardian Camp Authorization

I hereby have read the entire camp packet and have completed it to the best of my knowledge. I understand my child is not guaranteed a space at camp based on medical needs and space available. I understand if my child is able to attend camp, I will receive another packet in mid-June with further information and medical clearance.

Child/Camper Name:_____
Signature of Parent/Legal Guardian: _____
Date of signature: _____