OKIZU
Supporting Families with Childhood Cancer

Received: ______________________ Entered: ______________________

Okizu SIBS Camp Application 2017

(Special and Important Brothers and Sisters)

Applications are also available online. Visit www.okizu.org/apply to apply.

- This is a cost-free camp for Northern California children ages 6-17 who have a brother or sister who has or has had pediatric cancer.
- Please fill out one application per child. Call the Okizu office or photocopy if additional forms are needed.
- Please make sure your child's name is on the top of **every** page of this application.
- The application requires health history information. All 10 pages must be completed before you can submit the application.

Child's Name: ______________________________________ Age: __________

Mailing Address: ______________________________________ Grade in Fall: __________

City: ______________________________ State: ______ Zip: ______________

County: ______________________ Home Phone #: (_______)______________

Birthday: ________ /________ /________ Gender: ______________________

Parent/Guardian #1

Name: ______________________________ Home #: (_______)______________

Address: ____

Email: ______________________________ Cell #: (_______)______________

Employer: ______________________________ Work #: (_______)______________

Parent/Guardian #2

Name: ______________________________ Home #: (_______)______________

Address: ____

Email: ______________________________ Cell #: (_______)______________

Employer: ______________________________ Work #: (_______)______________

Family Status: ___ Married ___ Divorced ___ Separated ___ Single Mother ___ Single Father __________ Other

Custody: ____ Mother ____ Father ____ Joint ____ Grandparent(s) ____ Guardian(s) ______________ Other

Additional Emergency Contact Information

In an emergency we will always call the parents/guardians first. If we are not able to reach you we need two additional people that can be contacted in case of emergency. Please do not put yourself or your spouse as the emergency contact.

Emergency Contact #1
(Must be someone different than those listed above.)

Full Name: ______________________________ Relationship: ______________
First Last

Cell #: (_______)______________________ Home #: (_______)______________

Emergency Contact #2
(Must be someone different than those listed above.)

Full Name: ______________________________ Relationship: ______________
First Last

Okizu, 16 Digital Drive, Suite 130, Novato, CA 94949 TEL 415.382.9083 FAX 415.382.8384 enrollment@okizu.org

Child's Name: ______________________________

Cell #: (________)______________________________ Home #: (________)__________________________

Cancer Patient Information

Please complete all of this information even if the patient is no longer on treatment.

Name of brother or sister diagnosed with cancer: ______________________________

Child's cancer diagnosis: ______________________________

Date of diagnosis: ______________________ Date(s) of any relapse(s): ______________________

Cancer physician: ______________________________

Cancer treatment facility (select all that apply):

_____ California Pacific Medical Center, San Francisco

_____ Kaiser Permanente Oakland Medical Center

_____ Kaiser Permanente Santa Clara Medical Center

_____ Sutter Medical Center, Sacramento

_____ UCSF Benioff Children's Hospital Oakland

_____ John Muir Medical Center, Walnut Creek

_____ Kaiser Permanente Roseville Medical Center

_____ Lucile Packard Children's Hospital Stanford

_____ UC Davis Medical Center, Sacramento

_____ UCSF Benioff Children's Hospital San Francisco

Other: ______________________________

Current stage of treatment: _____ On treatment _____ Off treatment _____ Our family is bereaved

If off treatment, how long off treatment: ______________________________

2017 SIBS Camp Session Dates

Please select one session.

_____ June 19 – 25 _____ June 26 – July 2 _____ July 10 – 16 _____ July 17 – 23

Camper T-Shirt Size

Youth: _____ Small _____ Medium _____ Large

Adult: _____ Small _____ Medium _____ Large _____ XL _____ 2XL

Past Attendance

Has your child attended Okizu's SIBS Camp before? ________________ If yes, how many times? ______________

Has your child attended Okizu's Family Camp before? ______________ If yes, how many times? ______________

How did you hear about Okizu? Please select all that apply. ____Doctor ____Nurse ____Social Worker ____Friend

____Internet ____Other (please specify): ______________________________

Transportation

We offer roundtrip bus transportation from the following four locations. Camp Okizu is located 70 miles northeast of Sacramento.

On Monday, the first day of camp, I would like my child to ride the bus to camp from the following stop:

____ Palo Alto ____ East Bay ____ Sacramento ____ Fairfield ____ None, I will drive my child to camp.

On Sunday, the last day of camp, I would like my child to ride the bus from camp to the following stop:

____ Palo Alto ____ East Bay ____ Sacramento ____ Fairfield ____ None, I will pick my child up from camp.

Child's Name: ______________________________

I would be interested in chaperoning the bus: __________ Yes __________ No

Okizu SIBS Camp Health History Form

Please complete the following Health History form as part of your child's application. It is essential that we have current health information in order to ensure the safety and well-being of campers during their time at Okizu. This year we will require one medical form for SIBS campers who do not have conditions requiring treatment, restrictions, or other accommodations during their stay at camp. If your child requires a second form we will send it in their acceptance packet and it will require a doctor's signature. If you need more room, please continue your comments on a separate sheet of paper.

Height: ___________ feet and inches **Weight:** ___________ lbs **Last Exam Date:** (if known) ___________

Allergies and Dietary Restrictions

Does your child have any allergies? __________ Yes __________ No

If yes, this camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other

Please describe what the camper is allergic to and the reaction seen: ______________________________

____

Does your child require an EpiPen? __________ Yes __________ No

If yes, please provide details about your child's anaphylaxis, including the date and description of the reaction: ________________

____

**Send one non-expired EpiPen to camp with your child.*

Does your child have any dietary restrictions? __________ Yes __________ No

If yes, please explain: ____

____

**We can easily accommodate vegetarians and campers with a no red meat preference. If your child has other dietary restrictions please contact the Okizu office to discuss.*

Medications and Treatments

1. We cannot dispense any medication not in a prescription container, so please send original prescription container. Any remaining meds will be returned.
2. Due to the large number of medications that we need to dispense at camp, we request that you send only the essentials. No daily vitamins, over the counter pain relievers, or decongestants. We have a supply of these meds and will dispense them as necessary.
3. Meds are given at breakfast, lunch, dinner, and bed time unless absolutely necessary at other specific times.
4. For antibiotics or other meds taken for a limited time (i.e. days 1-20) please note day started.

Will your child be taking any medications while at camp? __________ Yes __________ No

**Medicine must be brought to camp in its original packaging.*

Drug Name/Strength: **Amount:** **Frequency:**

1.________________________________ Breakfast_______ Lunch_______ Dinner_______ Bed_______

2.________________________________ Breakfast_______ Lunch_______ Dinner_______ Bed_______

3.________________________________ Breakfast_______ Lunch_______ Dinner_______ Bed_______

4.________________________________ Breakfast_______ Lunch_______ Dinner_______ Bed_______

Child's Name: ______________________________

The following over-the-counter medications may be given to your child as needed, if deemed necessary, by the camp medical personnel. Over-the-counter medications used at Okizu include: Acetaminophen *(Tylenol)*, Ibuprofen *(Advil, Motrin)*, Antihistamines *(Benadryl, Claritin, Zyrtec etc.)*, combination cough/cold medicines, cough drops, sore throat spray, antacids, laxatives for constipation, Pepto-Bismol, aloe, antibiotic cream, calamine lotion, hydrocortisone cream, insect repellent, sunburn spray, sunscreen, and lice shampoo.

If your child can not take any of these medications, please list them below, along with the reason why the medication cannot be used: ______________________________

____

____

Will your child require any treatments while at camp? __________ Yes __________ No

If yes, please explain what treatment(s) must be given to your child, including the frequency? ______________________________

____

____

Does your child regularly take any medications that will not be taken at camp? _________ Yes _________ No

If yes, explain what medications your child takes regularly and why they are taken. ______________________________

____

____

Immunization History

Please attach a copy of your child's immunization record, or list the date of your child's most recent vaccination below:

Vaccine:	Dates: mo/yr	mo/yr	mo/yr	mo/yr	mo/yr
Diptheria, Pertussis, Tetanus (TdaP or DTdaP)	______	______	______	______	______
Tetanus booster (dT or TdaP)	______	______	______	______	______
MMR (Measels, Mumps, Rubella)	______	______	______	______	______
Polio (IPV/OPV)	______	______	______	______	______
Haemophilus Influenza B (HIB)	______	______	______	______	______
PCV (Pneumococcal)	______	______	______	______	______
Hepatitis A	______	______	______	______	______
Hepatitis B	______	______	______	______	______
Chicken Pox (Varicella)	______	______	______	______	______
Meningococcal Meningitis (MCV4)	______	______	______	______	______

If your child has not been fully immunized or has had any of the above illnesses, please explain. Please include dates and details. ______________________________

Has your child had a TB test? ______ Yes _______ No **Date of most recent TB test?** ______/______/______

What was the result of your child's most recent TB test? _____ Positive _____ Negative

If positive, please explain: ______________________________

Child's Name: ______________________________

Okizu SIBS Camp Health History

Has your child experienced, or are they currently experiencing any of the following conditions?
For any of the questions with a 'yes' answer, please inform us if the condition will require treatment, restrictions, or other accommodations while your child is at Camp Okizu. Please be specific and if you need more space please attach an extra sheet of paper.

Does your child have ADD/ADHD? __________ Yes __________ No
If yes, are they currently on medication? __________ Yes __________ No
If yes, will they be on medication while they are at camp? __________ Yes __________ No
Please explain any issues in relation to the ADD/ADHD diagnosis that we should know about: ____________________________

____

Does your child have behavioral issues? __________ Yes __________ No
If yes, please explain. Will they require treatment, restrictions, or accommodations while they are at camp? __________________

____

Does your child have developmental delays or mental health issues? __________ Yes __________ No
If yes, please explain. Will they require treatment, restrictions, or accommodations while they are at camp? __________________

____

Does your child have depression or an eating disorder? __________ Yes __________ No
If yes, please explain: ____

Does your child have asthma? __________ Yes __________ No
If yes, is the condition mild, moderate, or severe? Is it triggered by anything? ______________________________
If yes, do they carry an inhaler with them? ____
If yes, what else do we need to know about the asthma? ____

____

Does your child have problems breathing, coughing, or lung disease? __________ Yes __________ No
If yes, please explain: ____

Does your child have seizures, epilepsy, or convulsions? __________ Yes __________ No
If yes, how frequently and what is the date of the last seizure? ______________________________________
If yes, will they be on medication while they are at camp? ____
If yes, what else do we need to know about the seizures? ____

____

Does your child faint or have blackouts? __________ Yes __________ No
If yes, please explain: ____

Does your child have mobility issues, difficulty walking, braces, etc.? __________ Yes __________ No
If yes, please explain: ____

____

Does your child use a wheelchair? __________ Yes __________ No
If yes, what percentage of the time do they spend in the wheelchair? ____________________________________
If yes, is there anything additional we need to know? Will they require treatment, restrictions, or accommodations while they are at camp? ____

____

Does your child have a prosthesis or prosthetic joints? __________ Yes __________ No
If yes, please describe the location of prosthesis and any treatment, restrictions, or accommodations they will require while they are at camp: ____

Child's Name: ________________________________

Does your child have nightmares or night terrors? __________ Yes __________ No
If yes, please explain: ____

Does your child wet the bed or sleepwalk? __________ Yes __________ No
If yes, how often? Please explain: ____

Does your child have a concussion or get headaches? __________ Yes __________ No
If yes, please explain: ____

Does your child have visual impairment *(uses eyeglasses, contacts, etc.)***?** __________ Yes __________ No
If yes, please explain: ____

Does your child have speech problems? __________ Yes __________ No
If yes, please explain: ____

Does your child have hearing or other ear problems? __________ Yes __________ No
If yes, please explain: ____

Does your child have dental braces, caps, or bridges? __________ Yes __________ No
If yes, please explain: ____

Does your child get homesick? __________ Yes __________ No
If yes, please explain: ____

Does your child have neck pain or injury? __________ Yes __________ No
If yes, please explain: ____

Does your child have chest pain? __________ Yes __________ No
If yes, please explain: ____

Does your child have back pain or injury? __________ Yes __________ No
If yes, please explain: ____

Does your child have intestinal problems *(Crohn's/Colitis/Constipation/Diarrhea/Ulcer)***?** ________ Yes ________ No
If yes, please explain: ____

Does your child have kidney disease? __________ Yes __________ No
If yes, please explain: ____

Does your child have chronic Urinary Tract Infection? __________ Yes __________ No
If yes, please explain: ____

Does your child have chronic sinus infections? __________ Yes __________ No
If yes, please explain: ____

Does your child have diabetes? __________ Yes __________ No
If yes, please list the date of diagnosis and required care: ____

Does your child have heart disease? __________ Yes __________ No
If yes, please explain: ____

Does your child have high blood pressure? __________ Yes __________ No
If yes, please explain: ____

Does your child have a hernia? __________ Yes __________ No
If yes, please explain: ____

Child's Name: ________________________________

Does your child have menstrual difficulties? __________ Yes __________ No

If yes, please explain: ____

Does your child have a bleeding disorder? __________ Yes __________ No

If yes, please explain: ____

Does your child have skin problems? __________ Yes __________ No

If yes, please explain: ____

Does your child have autism? __________ Yes __________ No

If yes, please explain: ____

Does your child have Down Syndrome? __________ Yes __________ No

If yes, please explain: ____

Does your child have AIDS/ARC? __________ Yes __________ No

If yes, please explain: ____

Has your child had or do they currently have Hepatitis C? __________ Yes __________ No

If yes, please explain: ____

Has your child had or do they currently have Mononucleosis *(past 1 year)***?** __________ Yes __________ No

If yes, please explain: ____

Has your child had or do they currently have Scarlet Fever? __________ Yes __________ No

If yes, please explain: ____

Has your child traveled outside the country in the past 9 months? __________ Yes __________ No

If yes, please list countries and dates: ____

Has your child had any operations? __________ Yes __________ No

If yes, please explain the operation(s), including date(s): ____

____

*****It is important to note if prior operation(s) will affect your child's health while at camp.*

Has your child ever been hospitalized or had a serious injury? __________ Yes __________ No

If yes, please explain the reason(s) for hospitalization(s) or the serious injury(ies) and the dates they occurred: ________________

____

*****It is important to note any signs of illness that camp staff should look out for.*

Has your child been exposed to any communicable diseases within the last 3 months? _______ Yes _______ No

If yes, please explain what disease(s) your child has been exposed to, and when the exposure occurred: ____________________

____

Does your child have any restrictions on activity? _______ Yes _______ No

If yes, please explain what activities must be restricted and any special accommodations that should be made: ________________

____

Will your child require any special assistance while at camp*(getting dressed, showering, bathroom, etc.)***?** ____Yes____ No

If yes, please explain what assistance will be required: ____

____

Are there any custody issues we should know about? __________ Yes __________ No

If yes, please explain. Please be specific: ____

____

Child's Name: ______________________________

Does your child have any chronic medical conditions? __________ Yes __________ No

If yes, please describe: ____

____

____

____

Has your child experienced any stressful life events in the past year *(death of a family member, friend, or pet; divorce; marriage; deployment)***?** __________ Yes __________ No

If yes, please describe: ____

____

____

____

Please inform us of any other health conditions, mental or physical, that will require treatment, restrictions, or other accommodations while your child is at Camp Okizu. Please be specific. ______________________

____

____

____

Is there anything else you would like us to know about your child? ______________________

____

____

____

Health Insurance and Doctor Information

Doctor Information

Child's Doctor: ______________________________ **Phone #:** (________) ____________________

Health Insurance – attach a copy of your insurance card or complete the following:

Do you have medical insurance? __________**Yes** __________**No**

Full Name of Policy Holder: ______________________________

Policy Holder Phone Number: ______________________________

Employer Name ***(if insured through company)*****:** ______________________________

Insurance Company/Plan Name: ______________________________

Insurance Company Phone Number: ______________________________

Health Insurance Policy Number: ______________________________

Insurance Group Name or Number: ______________________________

Child's Name: ______________________________

Okizu SIBS Camp Authorization to Consent to Treatment of Minor Medical Waiver

I am the parent/guardian of ____, a minor. I authorize Okizu Camp personnel to (i) consent to any x-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment, and hospital care which is deemed advisable by any physician, dentist, or surgeon; and (ii) obtain a copy of any of my child's health records and to communicate with and receive information from any of my child's health providers about my child's health status or history.

I understand that reasonable measures will be taken to safeguard the health and safety of campers and that I will be notified as soon as possible in case of an emergency. However, in the event of my child's illness or accident, I will not hold Camp Okizu, the Okizu Foundation, or any of its directors, employees, or agents liable for harm to my child. This authorization shall remain effective until revoked in writing.

Please print name: ____ **Date:** ____________________

Signature: _______________________________________ **Relationship:** ___________________________

*****_If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance._

Demographic Information

The following questions are optional and will only be used to obtain funding from foundations that require this demographic information.

Ethnicity

_____ African American or Black
_____ Asian or Pacific Islander
_____ Caucasian
_____ Hispanic or Latino
_____ Native American
_____ Other

Income Level Annually

_____ Less than $24,999
_____ $25,000 - $49,999
_____ $50,000 - $74,999
_____ $75,000 - $99,999
_____ $100,000 - $124,999
_____ $125,000 - $149,999
_____ $150,000+

Photos

By participating in Okizu's programs, you are authorizing us to use photos or videos of you or your family in our brochures, on our website, or in any other fundraising or public relations material. If you do not wish us to use your images, you need to file a "No Photo Authorization" form with our office. **You need to renew this form every year.** Please call or email our office to obtain this form.

Acceptance Packet

Once this application is processed and approved, you will receive an acceptance packet via email or US Post.

How would you like to receive acceptance materials? _____ By Email _____ By US Post

If you choose email, please make sure you have provided a legible email address on the front page.

Would you prefer to receive the acceptance materials in Spanish? _____ Yes _____ No

Child's Name: ______________________________

We Would Love to Have Your Help

Occasionally we need volunteers to help with fundraising, to represent Okizu at networking events, etc. and we would love to have your help. If you would like to be added to the list of people whom we contact when we need help, please select the areas with which you be willing to help.

_____ Speaking engagements
_____ Submitting testimonials and writing letters
_____ Interviews
_____ Media opportunities
_____ Tabling events and Okizu info booths
_____ Okizu representative at events
_____ Fundraising event staff *(golf tournaments, auctions, etc.)*
_____ Other

Parent/Guardian Agreement

I, ____ agree to the following:
(Parent/Guardian Name)

- I certify that all information on this application is true and correct.
- I agree to abide by the rules and philosophy of Okizu.
- I have informed you of any special needs that will require attention during my child's stay at camp.
- I will review the rules and guidelines of expected behavior at Okizu with my child before his/her time at camp.
- Because there is no regularly scheduled transportation, if for any reason it is determined by the Okizu staff that my child must leave before the end of his/her session, I agree to be responsible for his/her transportation from Camp Okizu within 12 hours.

Parent or Guardian Signature: ______________________________ Date: ________________

Print Name: ____

Additional Comments:____

____
____
____
____
____
____
____
____
____

Mail completed applications to the Okizu office at the address below.

Okizu, 16 Digital Drive, Suite 130, Novato, CA 94949 TEL 415.382.9083 FAX 415.382.8384 enrollment@okizu.org