OKIZU
Supporting Families with Childhood Cancer

Okizu Teens-N-Twenties Camp Application 2017

- This is a cost-free camp for Northern California young adults who have or have had cancer or who have a brother or sister who has or has had cancer. TNT participants are between the ages of 18 and 25.
- The application requires health history information. All 10 pages must be completed before you can submit the application.
- The application should be completed by the program participant unless the program participant is unable to legally sign for themselves.

#1 _______ I am the TNT participant

#2 _______ I am the parent/guardian of a participant who is unable to legally sign for themselves. **Note:** The application is geared toward the participant completing it. Please fill out as if you are the participant and call us if you have any questions.

Name: ______________________________ Age: __________

Mailing Address: ______________________________

City: ______________________________ State: ______ Zip: __________

County: ______________________ Cell Phone #: (________)______________

Email: ______________________________

Birthday: __________ /__________ /__________ Gender: ______________________

2017 TNT Camp Session Dates

Please select which program or programs you would like to attend. You can sign up for multiple sessions now, or register for another session at any time.

____February 24 – 26***Snow trip** ____March 31 – April 2 ____October 27 – 29 ____December 8 – 10

Past Attendance

Which of the following programs have you participated in? Please check all that apply.

I have attended Okizu's Oncology Camp. _______ Yes _______ No

I have attended Okizu's SIBS Camp. _______ Yes _______ No

I have attended Okizu's Family Camp. _______ Yes _______ No

I have attended Okikzu's TNT weekends. _______ Yes _______ No

Transportation

We offer roundtrip bus transportation from the following four locations for all TNT weekends, including the snow trip. Camp Okizu is located 70 miles northeast of Sacramento.

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

____ Menlo Park ____ East Bay ____ Sacramento ____ Fairfield ____ None, I will drive myself to camp.

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

____ Menlo Park ____ East Bay ____ Sacramento ____ Fairfield ____ None, I will drive myself home from camp.

Participants Name: ______________________________

Cancer Patient Information for TNT

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

Name of person in family diagnosed with cancer: ____

Relationship to the patient? _____ I am the cancer patient ______ I am the brother or sister of the cancer patient.

_____ Other * If other, please explain. ____

Patient's 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: ____

Emergency Contact Information

Please provide two emergency contacts

Emergency Contact #1

Full Name: ____ Relationship: ____________________

First Last

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

Email: ____

Emergency Contact #2

Full Name: ____ Relationship: ____________________

First Last

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

Email: ____

Participants Name: ______________________________

Okizu TNT Program Health History Form

Please complete the following Health History form as part the application. It is essential that we have current health information in order to ensure the safety and well-being of participants during their time with Okizu. This year we will require one medical form for folks who do not have conditions requiring treatment, restrictions, or other accommodations during their stay at camp. If a second form is required, we will send it in the 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

Do you have any allergies? _________ Yes _________ No

If yes, what are you allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other

Please describe what you are allergic to and the reaction: ______________________________

____

Do you require an EpiPen? _________ Yes _________ No

If yes, please provide details about the anaphylaxis, including the date and description of the reaction: ______________________________

____

******Please bring at least one non-expired EpiPen with you.*

Do you have any dietary restrictions? _________ Yes _________ No

If yes, please explain: ______________________________

____

******We can easily accommodate vegetarians and folks with a no red meat preference. If you have other dietary restrictions, please contact the Okizu office to discuss.*

Medications

Will you be taking any medications while at camp? _________ Yes _________ No

If yes, please list all medications you will be taking below. If you are the parent/guardian completing this application and Okizu will be responsible for dispensing medications, please note the following:

1. We cannot dispense any medication not in a prescription container, so please send original prescription container. Any remaining meds will be returned.
2. Meds are given at breakfast, lunch, dinner, and bed time unless absolutely necessary at other specific times.
3. For antibiotics or other meds taken for a limited time (i.e. days 1-20) please note day started.

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______

Participants Name: ______________________________

The following over-the-counter medications may be given 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 you cannot take any of these medications, please list them below, along with the reason why the medication cannot be used: ______________________________

____

____

Will you require any treatments while at camp? __________ Yes __________ No

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

____

____

Do you regularly take any medications that will not be taken at camp? _________ Yes _________ No

If yes, explain what medications you take regularly and why they are taken. ______________________________

____

____

Immunization History

Please attach a copy of your immunization record, or list the date of your 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. ______________________________

Have you had a TB test? ______ Yes _______ No **Date of most recent TB test?** ______/______/______

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

If positive, please explain: ______________________________

Participants Name: ______________________________

Okizu TNT Program Health History Form

Have you 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 you are at Camp Okizu. Please be specific and if you need more space please attach an extra sheet of paper.

Do you have ADD/ADHD? __________ Yes __________ No

If yes, are you currently on medication? __________ Yes __________ No

If yes, will you be on medication while you are at camp? __________ Yes __________ No

Please explain any issues in relation to the ADD/ADHD diagnosis that we should know about: ______________________

____

Do you have behavioral issues? __________ Yes __________ No

If yes, please explain. Will they require treatment, restrictions, or accommodations while they are at camp? ______________

____

Do you 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? ______________

____

Do you have depression or an eating disorder? __________ Yes __________ No

If yes, please explain: ____

Do you have asthma? __________ Yes __________ No

If yes, is the condition mild, moderate, or severe? Is it triggered by anything? ______________________________

If yes, do you carry an inhaler with you? ____

If yes, what else do we need to know about the asthma? ______________________________________

____

Do you have problems breathing, coughing, or lung disease? __________ Yes __________ No

If yes, please explain: ____

Do you have seizures, epilepsy, or convulsions? __________ Yes __________ No

If yes, how frequently and what is the date of the last seizure? ______________________________________

If yes, will you be on medication while you are at camp? ______________________________________

If yes, what else do we need to know about the seizures? ______________________________________

____

Do you faint or have blackouts? __________ Yes __________ No

If yes, please explain: ____

Do you have mobility issues, difficulty walking, braces, etc.? __________ Yes __________ No

If yes, please explain: ____

____

Do you use a wheelchair? __________ Yes __________ No

If yes, what percentage of the time do you spend in the wheelchair? ______________________________________

If yes, is there anything additional we need to know? Will you require treatment, restrictions, or accommodations while you are at camp? ____

____

Do you have a prosthesis or prosthetic joints? __________ Yes __________ No

If yes, please describe the location of prosthesis and any treatment, restrictions, or accommodations you will require while you are at camp: ____

Participants Name: ______________________________

Do you have nightmares or night terrors? __________ Yes __________ No
If yes, please explain: ______________________________

Do you wet the bed or sleepwalk? __________ Yes __________ No
If yes, how often? Please explain: ______________________________

Do you have a concussion or get headaches? __________ Yes __________ No
If yes, please explain: ______________________________

Do you have visual impairment *(uses eyeglasses, contacts, etc.)***?** __________ Yes __________ No
If yes, please explain: ______________________________

Do you have speech problems? __________ Yes __________ No
If yes, please explain: ______________________________

Do you have hearing or other ear problems? __________ Yes __________ No
If yes, please explain: ______________________________

Do you have dental braces, caps, or bridges? __________ Yes __________ No
If yes, please explain: ______________________________

Do you get homesick? __________ Yes __________ No
If yes, please explain: ______________________________

Do you have neck pain or injury? __________ Yes __________ No
If yes, please explain: ______________________________

Do you have chest pain? __________ Yes __________ No
If yes, please explain: ______________________________

Do you have back pain or injury? __________ Yes __________ No
If yes, please explain: ______________________________

Do you have intestinal problems *(Crohn's/Colitis/Constipation/Diarrhea/Ulcer)***?** ________ Yes ________ No
If yes, please explain: ______________________________

Do you have kidney disease? __________ Yes __________ No
If yes, please explain: ______________________________

Do you have chronic Urinary Tract Infection? __________ Yes __________ No
If yes, please explain: ______________________________

Do you have chronic sinus infections? __________ Yes __________ No
If yes, please explain: ______________________________

Do you have diabetes? __________ Yes __________ No
If yes, please list the date of diagnosis and required care: ______________________________

Do you have heart disease? __________ Yes __________ No
If yes, please explain: ______________________________

Do you have high blood pressure? __________ Yes __________ No
If yes, please explain: ______________________________

Do you have a hernia? __________ Yes __________ No
If yes, please explain: ______________________________

Participants Name: ______________________________

Do you have menstrual difficulties? _________ Yes _________ No
If yes, please explain: ____

Do you have a bleeding disorder? _________ Yes _________ No
If yes, please explain: ____

Do you have skin problems? _________ Yes _________ No
If yes, please explain: ____

Do you have autism? _________ Yes _________ No
If yes, please explain: ____

Do you have Down Syndrome? _________ Yes _________ No
If yes, please explain: ____

Do you have AIDS/ARC? _________ Yes _________ No
If yes, please explain: ____

Have you had or do you currently have Hepatitis C? _________ Yes _________ No
If yes, please explain: ____

Have you had or do you currently have Mononucleosis *(past 1 year)***?** _________ Yes _________ No
If yes, please explain: ____

Have you had or do you currently have Scarlet Fever? _________ Yes _________ No
If yes, please explain: ____

Have you traveled outside the country in the past 9 months? _________ Yes _________ No
If yes, please list countries and dates: ____

Have you 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 health while at camp.

Have you 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.

Have you been exposed to any communicable diseases within the last 3 months? _______ Yes _______ No
If yes, please explain what disease(s) you have been exposed to, and when the exposure occurred: ______________________

____

Do you 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 you 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: ____

____

Participants Name: ______________________________

Do you have any chronic medical conditions? __________ Yes __________ No

If yes, please describe: ____

____

____

____

Have you 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 you are at Camp Okizu. Please be specific. ______________________________

____

____

____

Is there anything else you would like us to know? ____

____

____

____

Health Insurance and Doctor Information

Doctor Information

Doctor name: ______________________________________ **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: ____

Participants Name: ___________________________

If you are the participant, please complete Box # 1. If you are completing this application for someone who is not legally able to sign for themselves, please complete Box #2.

Box # 1

Okizu TNT Camp Authorization to Consent to Treatment Medical Waiver

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 health records and to communicate with and receive information from any of my health providers about my health status or history.

I understand that reasonable measures will be taken to safeguard the health and safety of campers and, in the event of illness or accident, I will not hold Camp Okizu, the Okizu Foundation, or any of its directors, employees, or agents liable for harm to me. 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.*

Box # 2

Okizu TNT Camp Authorization to Consent to Treatment of Adult Under Guardianship 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.*

Participants Name: ______________________________

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

Participant Agreement

I, ____ agree to the following:

- 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 stay at camp.

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