

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 4 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: _____

Country: _____ Cell Phone #: (_____) _____

Email: _____

Birthday: _____/_____/_____ Gender: _____

Past Attendance

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

___Oncology Camp ___SIBS Camp ___Family Camp ___TNT weekends

2017 TNT Camp Session Dates

Please select which program(s) 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

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, 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, 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 as much of this information as you can.

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.

_____ Other. *If other, please explain. _____

Cancer treatment facility (select all that apply):

_____ California Pacific Medical Center, San Francisco

_____ John Muir Medical Center, Walnut Creek

_____ Kaiser Permanente Oakland Medical Center

_____ Kaiser Permanente Roseville Medical Center

_____ Kaiser Permanente Santa Clara Medical Center

_____ Lucile Packard Children's Hospital Stanford

_____ Sutter Medical Center, Sacramento

_____ UC Davis Medical Center, Sacramento

_____ UCSF Benioff Children's Hospital Oakland

_____ UCSF Benioff Children's Hospital San Francisco

Other: _____

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

Emergency Contact #1

Full Name: _____ Relationship: _____
First Last

Cell #: (_____) _____ Home #: (_____) _____

Emergency Contact #2

Full Name: _____ Relationship: _____
First Last

Cell #: (_____) _____ Home #: (_____) _____

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

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.

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.

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 /no red meat preference. If you have other dietary restrictions, please contact the Okizu office to discuss.*

Will you be taking any medications, require any medical treatments, or procedures that you would like/ need the Okizu medical staff to help you with, or would need space/privacy for? _____Yes _____No

If yes, please list any medications, and let us know what else you might need help with. (If you are taking medications or have medical treatments or procedures that don't require assistance from the Okizu staff, then it's up to you whether to share that information with us). _____

Do you have any current/recent health issues that we should now about (such as surgery, seizures, serious infections, relapse, big changes in your medication schedule, new health problems, etc.)? _____Yes _____No

If you any have current health issues, please explain. _____

Do you have any physical challenges that you will need help with? Prosthetics? Use a wheelchair? Difficulty walking long distances? Balance or coordination problems? _____Yes _____No

If you have physical challenges, please explain. _____

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

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.*

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.

Please print name: _____ **Date:** _____

Signature: _____