



Received: _____ Entered: _____

Okizu SIBS Camp Application 2018

(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 make sure your child's name is on the top of **every** page of this application.
- The application requires health history information. All 8 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: _____ Cell #: (_____) _____

Address: _____

Email: _____ Home #: (_____) _____

Employer: _____ Work #: (_____) _____

Parent/Guardian #2

Name: _____ Cell #: (_____) _____

Address: _____

Email: _____ Home #: (_____) _____

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

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

Child's Name: _____

Cancer Patient Information

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

Name of sister or brother 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

_____ 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

If off treatment, how long off treatment: _____

2018 SIBS Camp Session Dates

Please select one session.

_____ June 18 – 24

_____ June 25 – July 1

_____ July 9 – 15

_____ July 16 – 22

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.

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

Okizu, 83 Hamilton Drive, Suite 200, Novato, CA 94949 TEL 415.382.9083 FAX 415.382.8384 enrollment@okizu.org

Child's Name: _____

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 the camper 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 the camper require an EpiPen? _____ Yes _____ No

If yes, please provide details about the camper's anaphylaxis, including the date and description of the reaction: _____

**Send one non-expired EpiPen to camp with the camper.*

Does the camper have any dietary restrictions? _____ Yes _____ No

If yes, please explain: _____

**We can easily accommodate vegetarians and campers with a no red meat preference. If the camper 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 the camper 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 cannot 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**

Diphtheria, 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

Please answer all of the following medical questions for your child.

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, developmental delays, autism, Down Syndrome, mental health issues, or behavioral issues? _____ Yes _____ No

If yes, please explain: _____

If yes, are they currently on medication for this diagnosis? _____ Yes _____ No

If yes, will they be on medication while they are at camp? _____ Yes _____ No

Will this diagnosis require treatment, restrictions, or accommodations while they are at camp? _____

Does your child get homesick or have separation issues when away from home? _____ Yes _____ No

If yes, please explain: _____

Does your child have depression or an eating disorder? _____ Yes _____ No

If yes, please explain: _____

Does your child have asthma, problems breathing, coughing, or lung disease? _____ Yes _____ No

If yes, please explain: _____

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

If yes, do they carry an inhaler with them? _____

Does your child have seizures, epilepsy, convulsions, fainting, or blackouts? _____ Yes _____ No

If yes, please explain: _____

If yes, how frequently and what is the date of the last seizure or episode? _____

If yes, will they be on medication while they are at camp? _____

If yes, what else do we need to know about the seizures or episodes? _____

Does your child have mobility issues, difficulty walking, braces, etc.? _____ Yes _____ No

If yes, please explain: _____

Does your child use a wheelchair, have a prosthesis, or prosthetic joints? _____ Yes _____ No

If yes, please explain: _____

If they use a wheelchair, what percentage of the time will it be used at camp? _____

Does your child have a history of concussions or get headaches? _____ Yes _____ No

If yes, please explain: _____

Does your child have trouble seeing clearly (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 a shunt (drains excess fluid from brain) or Ommaya Reservoir? _____ Yes _____ No

If yes, please explain: _____

Does your child have neck, chest, or back pain or injury? _____ Yes _____ No

If yes, please explain: _____

Okizu, 83 Hamilton Drive, Suite 200, Novato, CA 94949 TEL 415.382.9083 FAX 415.382.8384 enrollment@okizu.org

Child's Name: _____

Does your child have intestinal problems (Crohn's/Colitis/Constipation/Diarrhea/Ulcer)? _____ Yes _____ No

If yes, please explain: _____

Does your child have diabetes, heart disease, or high blood pressure? _____ Yes _____ No

If yes, please list the diagnosis, date diagnosed, and required care: _____

Does your child have a skin condition or bleeding disorder? _____ Yes _____ No

If yes, please explain: _____

Does your child wet the bed, sleepwalk, have nightmares, or night terrors? _____ Yes _____ No

If yes, please explain: _____

Has your child ever been hospitalized for a serious injury or operations? _____ Yes _____ No

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

Please inform us of anything you'd like us to know about your child. This includes any other health conditions, mental or physical, that will require treatment, restrictions, or any other accommodations while your child is at Camp Okizu. Please be specific. _____

Child's Name: _____

Health Insurance and Doctor Information

Doctor Information

Child's Pediatrician/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: _____

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

I am the parent/guardian of _____, a minor. I authorize Camp Okizu 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	Income Level Annually	_____ Less than \$24,999
	_____ Asian or Pacific Islander		_____ \$25,000 - \$49,999
	_____ Caucasian		_____ \$50,000 - \$74,999
	_____ Hispanic or Latino		_____ \$75,000 - \$99,999
	_____ Native American		_____ \$100,000 - \$124,999
	_____ Other		_____ \$125,000 - \$149,999
			_____ \$150,000+

Child's 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

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 | _____ Tabling events and Okizu info booths |
| _____ Submitting testimonials and writing letters | _____ Okizu representative at events |
| _____ Interviews | _____ Fundraising event staff (<i>golf tournaments, auctions, etc.</i>) |
| _____ Media opportunities | _____ 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: _____

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