



Received: \_\_\_\_\_ Entered: \_\_\_\_\_

# Okizu SIBS Camp Application 2019

(Special and Important Brothers and Sisters)

Applications are also available online. Visit [www.okizu.org/apply](http://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 9 pages must be completed before you can submit the application.

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Grade in Fall: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_ Primary Phone #: (\_\_\_\_\_) \_\_\_\_\_

Birthday: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender: \_\_\_\_\_

## **Parent/Guardian #1**

Name: \_\_\_\_\_ Home #: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Cell #: (\_\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: (\_\_\_\_\_) \_\_\_\_\_

## **Parent/Guardian #2**

Name: \_\_\_\_\_ Home #: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Cell #: (\_\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: (\_\_\_\_\_) \_\_\_\_\_

## **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: \_\_\_\_\_

Cell #: (\_\_\_\_\_) \_\_\_\_\_ Home #: (\_\_\_\_\_) \_\_\_\_\_

Child's Name: \_\_\_\_\_

### **2019 SIBS Camp Session Dates**

Please select one session.

\_\_\_\_\_ June 17 – 23    \_\_\_\_\_ June 24 – 30    \_\_\_\_\_ July 8 – 14    \_\_\_\_\_ July 15 – 21

### **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 pick my child up from 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

### **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? \_\_\_\_\_

### **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):

- |   |  |
|---|--|
| _____ Stanford Children's Health at CPMC, 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: \_\_\_\_\_

Child's Name: \_\_\_\_\_

### Additional Household Information

**Family Status:** \_\_\_ Married \_\_\_ Divorced \_\_\_ Separated \_\_\_ Single Mother \_\_\_ Single Father \_\_\_\_\_ Other

**Custody:** \_\_\_ Mother \_\_\_ Father \_\_\_ Joint \_\_\_ Grandparent(s) \_\_\_ Guardian(s) \_\_\_\_\_ Other

### Acceptance Information

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   |

How did you hear about Okizu? Please select all that apply. \_\_\_ Doctor \_\_\_ Nurse \_\_\_ Social Worker \_\_\_ Friend  
\_\_\_ Internet \_\_\_ Other (please specify): \_\_\_\_\_

### Demographic Information

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

- |                  |                               |                              |                           |
|------------------|-------------------------------|------------------------------|---------------------------|
| <b>Ethnicity</b> | ___ African American or Black | <b>Income Level Annually</b> | ___ 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+            |

### 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.

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. If your child has any conditions requiring treatment, restrictions, or other accommodations during their stay at camp, we will include a second medical form to be signed by a doctor in your acceptance packet. 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.*

**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:** \_\_\_\_\_

### **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 or mental health issues, or behavioral issues?** \_\_\_\_\_ Yes      \_\_\_\_\_ No

If yes, please explain \_\_\_\_\_

If yes, are they currently on medication? \_\_\_\_\_ Yes      \_\_\_\_\_ No

If yes, will they be on medication while they are at camp? \_\_\_\_\_ Yes      \_\_\_\_\_

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 \_\_\_\_\_

Child's Name: \_\_\_\_\_

**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 episode? \_\_\_\_\_

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

If yes, what else do we need to know about the episodes? \_\_\_\_\_

**Does your child have mobility issues, difficulty walking, braces, etc.?** \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

**Does your child use a wheelchair, 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: \_\_\_\_\_

**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 explain: \_\_\_\_\_

**Does your child have a skin condition or bleeding disorder?** \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

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

If yes, please explain: \_\_\_\_\_

**Has your child ever been hospitalized for a serious injury or operation?** \_\_\_\_\_ 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:

\_\_\_\_\_  
\_\_\_\_\_

**Child's Name:** \_\_\_\_\_

**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 other health conditions, mental or physical, that will require treatment, restrictions, or other accommodations while your child is at Camp Okizu. Please be specific.** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Medications

**Will your child be taking any medications while at camp?** \_\_\_\_\_ Yes \_\_\_\_\_ No

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.

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

**Drug Name/Strength:**

**Dosage & Frequency:**

1. \_\_\_\_\_ Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_ Bed \_\_\_\_\_

2. \_\_\_\_\_ Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_ Bed \_\_\_\_\_

3. \_\_\_\_\_ Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_ Bed \_\_\_\_\_

4. \_\_\_\_\_ Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_ Bed \_\_\_\_\_

Child's Name: \_\_\_\_\_

### Immunization History

Okizu requires immunization information and a **current tetanus booster** to attend camp. Because our camp program has a potential for communicable diseases, we recommend that program participants are appropriately immunized for, at a minimum, the following diseases: tetanus, mumps, measles, rubella, polio, pertussis (whooping cough), and diphtheria. This being said, we recognize that some individuals may not be fully immunized for reasons that are biophysical or of personal choice.

If the participant is not fully immunized or doesn't have a current tetanus booster before camp, you will need to complete the Exemption from Immunization Requirements form.

The participant's immunization status: Check one of the following:

- I attest that all immunizations required for the participant are up to date and I have provided the most recent dates below or will provide copies of immunization forms from my health-care provider or state or local government.
- The participant is not fully immunized. Please send me the Exemption from Immunization Requirements form.

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

<b>Vaccine:</b>	<b>Dates:</b>	<b>mo/yr</b>	<b>mo/yr</b>	<b>mo/yr</b>	<b>mo/yr</b>	<b>mo/yr</b>
<b>Diphtheria, Pertussis, Tetanus</b> (TdaP or DTdaP)	_____	_____	_____	_____	_____	_____
<b>Tetanus booster</b> (dT or TdaP)*	_____	_____	_____	_____	_____	_____
<b>MMR</b> (Measels, Mumps, Rubella)	_____	_____	_____	_____	_____	_____
<b>Polio</b> (IPV/OPV)	_____	_____	_____	_____	_____	_____
<b>Haemophilus Influenza B</b> (HIB)	_____	_____	_____	_____	_____	_____
<b>PCV</b> (Pneumococcal)	_____	_____	_____	_____	_____	_____
<b>Hepatitis A</b>	_____	_____	_____	_____	_____	_____
<b>Hepatitis B</b>	_____	_____	_____	_____	_____	_____
<b>Chicken Pox</b> (Varicella)	_____	_____	_____	_____	_____	_____
<b>Meningococcal Meningitis</b> (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: \_\_\_\_\_

**Health Insurance and 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: \_\_\_\_\_

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 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.*





Child's Name: \_\_\_\_\_

# Okizu SIBS Camp Consent Form 2019

I give consent for my child, \_\_\_\_\_, to attend Camp Okizu. I understand that activities in which my child might participate include, but are not limited to, swimming, boating, arts and crafts, group sports, archery, hiking, and ropes course.

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.

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 each year. Please call or email our office to obtain this form.

In an effort to communicate important information, last minute updates, bus schedule changes, and any potential emergency information, we may contact you by text. By participating in Okizu's programs, you are authorizing us to use your cell phone number to send text messages regarding your child's session(s) at Okizu. If you do not want to receive information via text, you need to complete an "Opt Out" form. Please call or email our office to obtain this form.

We are delighted to have the resources to provide bus transportation to and from Camp Okizu. By participating in our bus service you agree to adhere to the Okizu bus policy by being on time for drop off and pick up and making sure that you check in and out with the Okizu representative at your stop.

I give consent for all written material, such as poems or expressions in writing by my child, to be used for publicity purposes by Okizu and participating hospitals.

I have informed you of all the allergies or health conditions, mental or physical that will require treatment, restriction, or other accommodations while my child is at camp Okizu.

### Please initial applicable lines:

\_\_\_\_\_ I certify that all information on this application is true and correct.

\_\_\_\_\_ I consent to my child's participation in all activities at camp.

\_\_\_\_\_ I consent to my child's participation in all activities of the camp **except** as noted below.

X

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

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