OKIZU
Supporting Families with Childhood Cancer

Okizu Teens-N-Twenties Camp Application 2019

- 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 they're unable to complete it independently.

Check one of the following:

☐ I am the TNT participant

☐ I am the parent/guardian of the participant who is physically or mentally unable to legally sign for themselves.

If this application is being completed by anyone other than the participant, please explain the circumstances and by whom the form is being completed: ______________________________

____

____

Participant Information

Participant's Name: ______________________________ Age: __________

Mailing Address: ______________________________

City: ______________________________ State: ______ Zip: ______________

County: ______________________________ Primary Phone #: (________)______________________

E-mail Address: ______________________________

Birthday: __________ /__________ /__________ Gender: ______________________

Secondary Contact Information (optional)

Name: ______________________________ Age: __________

Mailing Address: ______________________________

City: ______________________________ State: ______ Zip: ______________

County: ______________________________ Primary Phone #: (________)______________________

E-mail Address: ______________________________

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 _____I'm new to Okizu

Participant Name: ___________________________

2019 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.

_____ March 1- 3 _____ August 23 -25 _____ December 6 - 8

Cancer Patient Information

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

Name of person in family diagnosed with cancer: ____

Cancer diagnosis: ____

Relationship to the patient:

_____ I am the cancer patient _____ I am the brother or sister of the cancer patient. _____ Other

*If other please explain:____

Cancer treatment facility, if known (select all that apply):

_____ Stanford Children's Health at CPMC, 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

Additional Emergency Contact Information

Please list two additional people that can be contacted in case of emergency. One emergency contact must be local.

Emergency Contact #1

Full Name: ______________________________ Relationship:____________________

Cell #: (_________)______________________ Home #:(_________)____________________

Emergency Contact #2

Full Name: ______________________________ Relationship: ____________________

Cell #: (_________)______________________ Home #: (_________)____________________

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

Participant 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.

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're allergic to and the reaction seen:____

____

____

Do you require an EpiPen? __________ Yes __________ No

If yes, please provide details about your 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 campers with a 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 (such as surgery, seizures, serious infections, relapse, medications, etc.)? _____Yes _____No

If yes, 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 yes, please explain: ____

____

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

____

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

Participant 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: ____

Box #2 - Okizu TNT Camp Authorization to Consent to Treatment of Adult Under Guardianship Medical Waiver

I am the parent/guardian of ____, a participant who is legally unable to sign for themselves. 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:** ____________________________

Participant Agreement

I, ____ have filled out this application for myself, and 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 all the allergies or health conditions, mental or physical that will require treatment, restriction, or other accommodations while at camp Okizu.

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

Signature: ____