OKIZU
Supporting Families with Childhood Cancer

Received:_____ Entered: _____

Okizu SIBS Camp Application 2020

(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 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 8 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:_____

We use text messaging to convey information. To make sure you don't miss any updates please provide us with a valid cell phone #: (_____) _____

Parent/Guardian #1

Name:_____ Cell #: (_____)_____

Address:_____

Email:_____ Home #: (_____)_____

Employer:_____ Work #: (_____)_____

Parent/Guardian #2

Name:_____ Cell #: (_____)_____

Address:_____

Email:_____ Home #: (_____)_____

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: _____

2020 SIBS Camp Session Dates

Please select one session.

_____June 15 – 21 _____June 22 – 28 _____July 6 – 12 _____July 13 – 19

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 up 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

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
_____ Submitting testimonials and writing letters
_____ Interviews
_____ Media opportunities
_____ Tabling events and Okizu info booths
_____ Okizu representative at events
_____ Fundraising event staff *(golf tournaments, auctions, etc.)*
_____ 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.

Ethnicity_____African American or Black
_____ Asian or Pacific Islander
_____ Caucasian
_____ Hispanic or Latino
_____ Native American
_____ Other

Income Level Annually

____ Less than $24,999
____ $25,000 - $49,999
____ $50,000 - $74,999
____ $75,000 - $99,999
____ $100,000 - $124,999
____ $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 all medication in the 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: _____

Okizu Immunization Policy

Because children with cancer have a suppressed immune system and are not able to adequately defend themselves against certain infections, Okizu requires immunization information to attend camp. Program participants must be appropriately immunized for, at a minimum, the following diseases: chicken pox, influenza, tetanus, mumps, measles, rubella, polio, and pertussis (whooping cough). Because the risk to our campers is high, the only exceptions that will be made for the immunization requirement is a valid medical exemption. Valid exemptions will cover children on cancer therapy or recovering from treatment who have inadequate immune function to appropriately respond to the vaccines, and in the case of certain live virus vaccines, siblings of cancer patients who are at high risk because of their treatment.

Immunization History

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 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 the participant's immunization record and list the date of the participant's most recent tetanus shot below:

Tetanus shot **mo/yr:**_____

TB Risk Assessment

Please answer yes or no to the following questions for the participant. We will review all assessments and follow up as deemed necessary by our medical staff.

1. Has the participant ever been treated for TB? _____Yes _____No
2. Has the participant ever had a positive TB Skin Test (PPD) or blood test (I-Gold) _____Yes _____No
3. Has the participant ever had the BCG (TB) Vaccine? _____Yes _____No
4. Does the participant have any of the following symptoms?
    a. Productive or Persistent cough for over 2 weeks? _____Yes _____No
    b. Night Sweats _____Yes _____No
    c. Fever _____Yes _____No
    d. Weight Loss _____Yes _____No
    e. Loss of Appetite _____Yes _____No
5. Has the participant ever had an extended stay (6 months or more) in Africa, Asia, the Middle East, the Pacific Islands, or any of the following countries: Argentina, Bahamas, Belize, Bolivia, Brazil, Costa Rica, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Venezuela, Belarus, Bosnia, Herzegovina, Bulgaria, Croatia, Estonia, Hungary, Latvia, Lithuania, Macedonia, Moldova, Poland, Portugal, Romania, Russia, Serbia, Slovak Republic, Slovenia, Ukraine, or Yugoslavia? _____Yes _____No

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.*