



Okizu Bereaved Teen Program Application 2019

Applications are also available online. Visit www.okizu.org/apply to apply.

- This is a cost-free camp for Northern California children who are at least 13-years-old and who have lost their sibling to pediatric cancer.
- Please fill out one application per camper. Call the Okizu office or photocopy if additional forms are needed.
- If the camper is 13-17-years-old, this form must be completed and signed by a parent or guardian. If the camper is 18-years-old or older, this form can be completed and signed by the camper or by a parent or guardian but must include all information, including guardian and emergency contact information. Please make sure the camper'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.

Camper's Name: _____ Age: _____

Mailing Address: _____ Grade in Fall: _____

City: _____ State: _____ Zip: _____

County: _____ Home 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 the camper's parents or guardians as the emergency contacts.

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 #: (_____) _____

Camper's Name: _____

2019 Bereaved Teen Program Dates

Please indicate all sessions the camper would like to attend.

_____ April 5 – 7 _____ October 11 – 13

Transportation

We offer roundtrip bus transportation from the following four locations. Camp Okizu is located 70 miles northeast of Sacramento.

On Friday, the first day of camp, I would like the camper 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 the camper 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.

Past Attendance

Has the camper attended Okizu's Bereaved Teen programs before? _____ If yes, how many times? _____

Has the camper attended Okizu's SIBS Camp before? _____ If yes, how many times? _____

Has the camper attended Okizu's Family Camp before? _____ If yes, how many times? _____

Cancer Patient Information

Name of brother or sister diagnosed with cancer: _____

Child's cancer diagnosis: _____

Date of diagnosis: _____

Date of death: _____

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

_____ UCSF Benioff Children's Hospital Oakland

_____ UCSF Benioff Children's Hospital San Francisco

Other: _____

Camper's Name: _____

Additional Household Information

Acceptance Information

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

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 kind of 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+

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.

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

Camper's Name: _____

Okizu Bereaved Teen Program Health History Form

Parents of participants under 18: 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.

Participants who are over 18: Please complete the following Health History Form as part of your application. Although it says your child in each question, please answer this pertaining to your own health history.

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.*

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: _____

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 _____ No

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

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

If yes, please explain: _____

Camper's Name: _____

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 visual impairment (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 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 get homesick or have separation issues when away from home? _____ 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:

**It is important to note any signs of illness that camp staff should look out for.*

Camper'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: _____

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. _____

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 the camper 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:

Amount:

Frequency:

1. _____ Breakfast _____ Lunch _____ Dinner _____ Bed _____

2. _____ Breakfast _____ Lunch _____ Dinner _____ Bed _____

3. _____ Breakfast _____ Lunch _____ Dinner _____ Bed _____

4. _____ Breakfast _____ Lunch _____ Dinner _____ Bed _____

Camper'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 the participant's immunization record, or list the date of the participant'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 the participant has not been fully immunized or has had any of the above illnesses, please explain. Please include dates and details.

Has the participant had a TB test? _____ Yes _____ No

Date of most recent TB test? _____/_____/_____

What was the result of the participant's most recent TB test? _____ Positive _____ Negative

If positive, please explain: _____

Health Insurance and Doctor Information

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: _____

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 Bereaved Teen Weekend Authorization to Consent
to Treatment Medical Waiver**

If the camper is 13 to 17-years-old, this form **must** be completed and signed by a parent or guardian. If the camper is 18-years-old or older, this form can be completed and signed by the camper.

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.

OR

My name is _____. 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.

In the event of my illness or accident, I will not hold Camp Okizu, the Okizu Foundation, or any of its directors, employees, or agents liable for harm to myself. 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.*



Camper's Name: _____

Okizu Bereaved Teen Program Consent Form 2019

If the camper is 13 - 17-years-old, this form **must** be completed and signed by a parent or guardian. If the camper is 18-years-old or older, this form can be completed and signed by the camper.

I give consent for myself/my child, _____, to attend Camp Okizu. I understand that activities in which myself/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 myself/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 the participant is at camp Okizu.

Please initial applicable lines:

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

_____ I consent to my/my child's participation in all activities at camp.

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

X

Parent/Guardian or Camper Signature

Date

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

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