The Hemophilia Foundation of Northern California

B-Leaders Retreat Application 2017

For Identification purposes please attach photo here

Is this your first year at B- Leaders? ☐ YES ☐ NO

Camper General Information(all campers)

First Name_____ Last Name_____ Male☐ Female☐

Address_____City_____State_____Zip_____

Birthdate_____ Height_____ Weight_____ Grade as of 4/2017_____ Age as of 4/2017_____

Email:_____ Cell Phone_____

Parent/Guardian Information (all campers)

Contact #1	Parent/Guardian Last Name	First Name	Relationship
	Day Phone	Evening Phone	Cell Phone
Contact 2	Parent/Guardian Last Name	First Name	Relationship
	Day Phone	Evening Phone	Cell Phone

Who lives in the same home as the Camper? (check all that apply) Both Parents☐ Mother☐ Father☐ Step Mother☐

Step Father☐ Grandmother☐ Grandfather☐ Other☐ Brother/s (how many)____ Sister/s (how many)_____

If other than BOTH parents, who has legal custody of child? Mother ☐ Father☐ Other ☐ _____

If you will be away from home while your child is at camp please indicate where you can be reached.

Dates Away_____ Phone_____

Rarely, for medical or behavioral reasons, it is necessary to send a child home. Please indicate a person with will be responsible for picking up your child from camp, if necessary while you are away from home.

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

Emergency Contact – Person to be contacted if parents cannot be reached (all campers)

Camper Name_____ Date of Birth _____

Name of Hemophilia Treatment Center or Physician (all campers)

Campers Physician	Pediatrician
Hematologist	Institution
HTC	Address
Address	Phone
Phone	☐ Affected Camper ☐ Unaffected Camper
DOB_____ Height_____	Weight_____

B. DIAGNOSIS (all affected campers)
A. DOES YOUR CHILD HAVE A BLEEDING DISORDER Yes ☐ No ☐ (fill out section B)

Factor 8	Factory Activity Level %
Factor 9	Inhibitor? Yes ☐ No ☐ Inhibitor Tier
VWD 1__ 2__ 2a__ 2b__ 2c__	Date of last inhibitor test _____
Carrier 8 ___ 9 ___	Immune Tolerance?
Other Factor Deficiency	☐Now ☐Past ☐Never

Does your child have asthma? ☐ YES ☐ No

If yes: Asthma medications _____

Does your child have any other medical conditions? ☐ YES ☐ No

If yes: explanation _____

Does your child have any allergies to medication? ☐ YES ☐ No

If yes: medication_____ Reaction _____Treatment Needed_____

Does your child have any food allergies: ☐ YES ☐ No

If yes: Food_____ Reaction _____Treatment Needed_____

List any other medications that will be given at Camp.

All medications administered (including over-the-counter and vitamins) must appear on your child's medical form. You should send all medications, clotting factor, Stimate and any other supplies necessary for your child while at camp in the original bottle. The medical staff will store and administer medications as directed by you. This includes allergy meds, anti-depressants & vitamins.

Medication	Dose	Fri	Sat	Sun	As Needed

Does your child have frequent nose bleeds? ☐ YES ☐ No

If yes: How do you treat them?_____

TREATING BLEEDING EPISODES

Does your child have a Mediport or Brovic? ☐ YES ☐ NO

IF YES: DO YOU WANT THE DEVICE USED?

DOES YOUR CHILD SELF INFUSE? □ YES (INDEPENDENTLY) □ YES (NEEDS HELP) □ NO (BUT WOULD LIKE TO)

Is your child on Prophylaxis? □YES□NO

IF NO PLEASE INDICATE DOSAGE OF FACTOR AND SEND ENOUGH FOR AT LEAST 3 DAYS OF A MAJOR BLEED

Factor Name_____ Dosage of Factor to be used_____ (medical staff will determine length of treatment)

Minor/Soft Tissue Bleed _____

Major/Joint/Trauma Bleed _____

IF YES PLEASE INDICATE DOSAGE OF FACTOR AND SEND ENOUGH FOR AT LEAST 3 DAYS OF A MAJOR BLEED

PROPHYLAXIS SCHEDULE

Factor Name: (circle one)

Advate Alphanate Alphanine Alprolix

Benefix Elocate FEIBA Helixate FS

Hemophil M Humate – P Kogenate FS NovoSeven

Recombinate Rixubis Stimate Wilate Xyntha

Other (name)_____

DOSE TO BE GIVEN AT CAMP EACH DAY

Friday	Saturday	Sunday

EXAMPLE: KOGENATE

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
2500 UNITS		2500 UNITS		1500 UNITS	

Does your child self infuse: □ YES □ NO

IF NO:

Do you want your child to learn self-infusion? □ YES □ NO

Does your child have a central venous access line? □ YES □ NO

1. Broviac 2. Mediport

Do you want the device used? □ YES □ NO

*If NO then your child will be taught self-infusion and the device will

Only be used in the event that an alternative access cannot be obtained.

PARENT COMPLETED QUESTIONNAIRE

Childs Name_____

Has your child ever been away from home? □ YES □ NO

Has your child repeated a grade? (if yes, which year?) □ YES □ NO

Have there been any stressful life events in the past year? (if yes, please explain) □ YES □ NO

Has your child ever seen a therapist or psychiatrist? (if yes please explain) □ YES □ NO

Does your child have specific fears, anxieties or worries? (if yes please explain) □ YES □ NO

Do you have any concerns about your child's behavior? □ YES □ NO

□ ADD/ADHD □BEDWETTING □TROUBLE SLEEPING □OTHER_____

Level of Assistance for your child	(all campers)

Does your child require 1:1 care throughout the day? □ YES □NO (if no please skip to next section)

Daily Care (brushing teeth, combing hair, dressing)	□Independent	□ Close Supervision	□Moderate Supervision	□Total Care
Meals	□Independent	□ Close Supervision	□Moderate Supervision	□Total Care
Bathing/Showering	□Independent	□ Close Supervision	□Moderate Supervision	□Total Care
Toileting/Bathroom	□Independent	□ Close Supervision	□Moderate Supervision	□Total Care

Behavioral Concerns	(all campers)

□Shyness □Anger Management □Other_____ □Other_____

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INDEMNIFICATION

CONSENT TO PHOTOGRAPH:

I/WE hereby authorize the Hemophilia Foundation of Northern California to photograph the above named minor in connection with his/her presence at Camp Oakhurst. The photographs may appear in hospital, HFNC, and or public newspaper camp publicity. □Yes □No

X_____ _____

Signature of parent of guardian Date

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Physician's Form

TO BE COMPLETED BY HEALTHCARE PROVIDER

Name of Patient_____ DOB_____

Date of last Exam_____ Weight_____ □ Male □ Female

Diagnosis

Affected by Bleeding Disorder □YES □NO

Factor 8___ Factor 9 _____

VWD 1____ 2 _____ 3____

2A_____ 2B____ 2M____ 2N____

Symptomatic carrier_____

Carrier 8_____ 9_____

Other factor deficiency (type) _____

Platelet dysfunction (type)_____

Factor Activity Level _____%

Inhibitor? □Yes □No Inhibitor Titer_____

Date of last inhibitor test _____

Immune Tolerance? □On it now □On it in the past

Treatment

What brand of factor is used?_____

Does this child self-infuse? □YES □YES with assistance □No □No, but would like to learn

Target joints?_____

Factor Therapy	Minor		Major	
	Factor Dose	Frequency	Factor Dose	Frequency
Prophylactic Therapy				
Minor bleeds/soft tissue of muscle				
Joint bleeds				
Major bleeds				
Trauma or head injury				

Other Meds for Bleeding episodes	Dose	Frequency

Psychosocial Development

Is the child's development appropriate for his/her age? □YES □NO

If NO, at what age (approx) does the child function?_____

Pertinent Psychosocial Information (any member of medical team may complete)

_____

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Physician's Form

TO BE COMPLETED BY HEALTHCARE PROVIDER

Patient Name _____

Patient Information			Explain Abnormalities
lead & Neck	□Normal	□Abnormal	
yes & Ears	□Normal	□Abnormal	
lose & Throat	□Normal	□Abnormal	
ental	□Normal	□Abnormal	
hest	□Normal	□Abnormal	
leart	□Normal	□Abnormal	
bdomen	□Normal	□Abnormal	
xtremities	□Normal	□Abnormal	
leurological	□Normal	□Abnormal	
kin	□Normal	□Abnormal	
sychological	□Normal	□Abnormal	
leight/Weight	□Normal	□Abnormal	

Allergies (drug, food or clotting)

	Name	Reaction	Name	Reaction
Medicine				
Food				

If the child had any hospitalizations in the past year, please give dates and reasons_____

_____

_____

Please list any ongoing other problem(s) / other diagnosis

Any General Restrictions?

_____ _____

Signature of Provider (MANDATORY) Print Name

_____

Clinic Address Emergency/Phone Date

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IMMUNNIZATION DATES

PLEASE NOTE ALL CHILDREN MUST BE FULLY VACINATTED TO ATTEND

(PLEASE COMPLETE OR INCLUDE A COPY OF IMMUNIZATION RECORDS)

Hepatitis B	1
	2
	3
	4
Polio	1
	2
	3
	4

Rotavirus	1
	2
	3
	4
MMR	1
	2
	3
	4

DPT	1
	2
	3
	4
	5
	6
Hepatitis A	1
	2
	3
	4

Homophiles Influenza Type B	1
	2
	3
	4
Influenza	1
	2
	3

HPV	1
	2

	3
	4
Meningococcal Meningitis	1
	2
	3
	4

Pnemococcal	1
	2
	3
	4

Chickenpox	1
	2

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Registration and Application Fees

B-Leaders Retreat Application Donation

A $50 application fee should accompany each application.

You may request to have the application fee reduced or waived by enclosing a letter describing your financial needs.

B-Leaders Application Donation

We request a camper registration donation from each family to accompany your application.

Family Annual Income			Suggested Donation Per Family
Up to		$20,000	$0
$20,000	To	$35,000	$50
$35,000	To	$45,000	$100
$45,000	To	$55,000	$150
$55,000	To	$65,000	$200
$65,000	To	$75,000	$300
$75,000	To	$90,000	$400
$90,000	To	$100,000	$500
$100,000	To	$120,000	$700
$120,000	To	$135,000	$800
$135,000	To	$150,000	$900
Over		$150,000	$1000

Total Fees Enclosed

B-Leader Application Donation (or letter stating financial need) $50.00

TOTAL $_____

Camper Name (s): _____

_____

_____

If you have any questions, please call the foundation at 510-658-3324

NO child will be denied the privilege of attending due to lack of funds.

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WHAT TO BRING - CHECKLIST

(*depending on weather)

MUST HAVE ITEMS			
□ Towels for swimming & showering	□ 2 pairs pajamas	□underwear/socks for 3 days	□Pillows
□sleeping bag (or sheets & blankets)	□ pair shorts(cutoffs)	□ pants/sweats/jeans (etc) for 3 days	□Comb/brush
□2 pairs comfortable shoes	□Bathing Suit	□Warm Jacket	□Sun Screen
□Bug repellant	□Toiletries	□Sweater/Sweatshirt	□Soap
□3 short sleeved shirts	□Toothbrush/toothpaste	□*closed toe shoes	
Might Want to Have Items	□ Musical Instrument □Light weight rope	□ journal/diary	□Sun Hat □Flashlight □ flip-flops for shower

THINGS TO LEAVE AT HOME			
Money	Knives/weapons of any kind	Portable TV's	Boomboxes
Ipods/Ipads/Mp3 players	BB guns	Pets/animals	Candy/food
Laptops/tablets			

IF ANY OF THESE ITEMS ARE BROUGHT TO CAMP, THEY WILL BE CONFINSCATED BY THE CAMP DIRECTOR AND HELD UNTIL END OF CAMP.