A retreat for children with life-threatening illnesses and their families

2019 Solid Organ Transplant Camp Information

Thank you for your interest in attending Camp Sunshine. Pages 1-3 of the application are for families to complete. Pages 4-6 are for your transplant team to complete.

Eligibility Guidelines

- The child who has had a solid organ transplant must be **18 years of age or younger**
- If both parents/ legal guardians are unable to attend, a second adult may attend as a support person and should be included on the application.
- **Immunization records** are required for everyone under 26 years of age applying to attend.
- Completed applications will be reviewed on a first-come, first-served basis, and should be received **at least one month prior to the session start date.** (If seeking to apply within one month of the program, please call Camp Sunshine to inquire about availability.)
- Families may attend once per program year.

Things to Know About Camp

- Meals, lodging, and activities are all provided at no cost to families, thanks to the generosity of our donors.
- A physician is present on-site during all Camp Sunshine sessions.
- Family suites can comfortably sleep 6 and include a private bathroom, heat/AC, a mini-fridge, and microwave oven.
- Transportation assistance may be available for families who would otherwise be unable to attend Camp. Funding is prioritized for families attending for the first time. Please indicate your request for transportation funding on the first page of the application. If funding is requested, you will receive further information at the time of acceptance.
- You will be contacted once your application has been processed. Acceptances and other updates will be provided as soon as possible.

Applications may be mailed or faxed to:

Camp Sunshine
35 Acadia Road
Casco, ME 04015
Phone: (207) 655-3800
Fax: (207) 655-3825
www.campsunshine.org

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2019 Solid Organ Transplant Application Checklist

Please use the following checklist to ensure that your family's application is complete.

❑ Family Forms

- Pages 1-3 of the application, to be completed by the parent/guardian

❑ Physician Forms

- Pages 4-6 of the application, to be completed by your child's specialist

❑ Immunization Records

- A complete and up-to-date immunization record must be included for each person under 26 years of age who is applying to attend Camp.
- For the optimal health and safety of all campers, staff, and volunteers, Camp Sunshine requires that all campers who can receive immunizations meet the age-appropriate immunization schedule as set forth by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
- At a minimum, campers aged 5 years and older should meet the same immunization requirements as those for school-aged children set forth in the State of Maine School Immunization Law (20-A MRSA §§6352-6358):
    - 5 DTaP (4 DTaP if the 4th is given on or after the 4th birthday)
    - 4 Polio (if the 4th dose is given before the 4th birthday, an additional age-appropriate inactivated polio immunization should be given on or after the 4th birthday)
    - 2 MMR (measles, mumps, rubella)
    - 1 Varicella (chickenpox) or reliable history of disease
- Camp Sunshine also requires that children aged 11 and older receive meningococcal vaccine and TDaP booster prior to attendance.

❑ Health History Forms

- A separate Health History form is required for each person (including adults) planning to attend Camp, with the *exception* of the child who has received a solid organ transplant. The Health History forms do not require a physician signature.

❑ Session Selection

- Please select three session dates, ranked 1-3 in order of preference, on the first page of the application.
- After your completed application has been reviewed and approved, you will be notified of your assigned session.
- In placing families, we take into consideration your preferences, timeliness of your application, session capacity, diagnoses, and group composition. We appreciate your understanding and flexibility as we work to meet the needs of the many families who apply.

CAMP SUNSHINE

A retreat for children with life-threatening illnesses and their families

☐ Check if Requesting Travel Assistance

Boston Children's Hospital Solid Organ Transplant Program
April 13 – 16, 2019
Family Application

Please print clearly using black or blue ink.

CAMPER INFORMATION

Child's Last Name _____ **Child's First Name** _____

Name as you would like it to appear on child's nametag _____

Gender _____ **Child's Date of Birth** ____/____/____

Child's Diagnosis _____ **Date of Diagnosis** ____/____/____

Address _____ Apt _____ City _____ State _____ Zip _____

Home telephone _____ E-mail _____

Treatment Center _____

Address _____ City _____ State _____ Zip _____

Physician (Specialist) _____ Telephone _____

Social Worker _____ Telephone _____

Child Life Specialist _____ Telephone _____

Health Insurance Company _____ Telephone _____

Policy Holder _____ Policy No. _____ Group No. _____

Prior Attendance – This will be our (please circle one) 1st time 2nd time 3rd time 4th time ____ th time at Camp.

How did you hear about Camp Sunshine? Name _____

FOR OFFICE USE ONLY

****

❑ Family Forms ❑ Immunizations ❑ Physician Forms ❑ Health History Forms

FAMILY INFORMATION

Name of parent(s) or guardian(s) child lives with: _____

Marital status (please indicate marital status of parents and explain any particular familial circumstances and/or custodial arrangements of which we should be aware):_____

_____

Parent/Legal Guardian_____
Relationship to child_____
Date of Birth _____/_____/_____
Address _____
City, State, Zip _____
Home Phone _____
Cellular phone _____
E-mail _____
Employer _____
Have you been in the Armed Forces? ❑ Yes ❑ No
Have you been in the Reserves? ❑ Yes ❑ No

Parent/Legal Guardian 2: _____
Relationship to child_____
Date of Birth ____/____/_____
Address _____
City, State, Zip _____
Home Phone _____
Cellular phone _____
E-mail _____
Employer _____
Have you been in the Armed Forces? ❑ Yes ❑ No
Have you been in the Reserves? ❑ Yes ❑ No

Emergency Contact (someone who will ***not*** be attending Camp with you**)**

Name_____ Relationship _____ Telephone _____

WHO WILL BE ATTENDING CAMP WITH THE CHILD?

One adult support person may be permitted to accompany a single parent/guardian or a parent/guardian whose partner cannot attend.

Parents'/Legal Guardians'/ Support Person's Names	**Relationship to camper**	**Medical or Emotional diagnosis/ concern? If "Yes," please explain and include on Health History Form**
1. _____	_____	❑ No ❑ Yes_____
2. _____	_____	❑ No ❑ Yes_____

Sibling's/ Support Person's Child(ren)'s Names	**Relationship/ Age at time of Camp**	**Medical or Emotional diagnosis/ concern? If "Yes," please explain and include on Health History Form**
1. _____	_____/____yr	❑ No ❑ Yes _____
2. _____	_____/____yr	❑ No ❑ Yes _____
3. _____	_____/____yr	❑ No ❑ Yes _____
4. _____	_____/____yr	❑ No ❑ Yes _____
5. _____	_____/____yr	❑ No ❑ Yes _____
6. _____	_____/____yr	❑ Yes ❑ No _____

***PLEASE NOTE: ALL CHILDREN UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY A PARENT AND/OR LEGAL GUARDIAN WHEN ATTENDING CAMP. IF A LEGAL GUARDIAN WILL BE ACCOMPANYING A CHILD TO CAMP, ORIGINAL NOTARIZED COURT DOCUMENTATION CONFIRMING THE GUARDIANSHIP MUST BE INCLUDED WITH THIS APPLICATION. IF MARITAL STATUS IS SEPARATED OR DIVORCED, PARENTS/LEGAL GUARDIANS MAY BE REQUIRED TO PROVIDE ADDITIONAL INFORMATION.**

CHILD'S GENERAL MEDICAL HISTORY

THE MORE INFORMATION WE HAVE, THE BETTER UNDERSTANDING WE WILL HAVE OF YOUR CHILD'S NEEDS

Primary language: _____ Secondary Language: _____
Additional medical problems (allergies, asthma, diabetes, etc.): _____
Drug allergies: _____
Dietary restrictions or food allergies: _____
Physical limitations: _____
Mobility (e.g., wheelchair, crutches, amputation): _____
Special medical needs/care requirements (vision/hearing loss): _____
Does your child have seizures? ❑ Yes ❑ No If so, how frequently do they occur?_____
Please describe the type of seizure: _____
What treatment is necessary for the seizures? _____ When was the last seizure? _____
Is your child incontinent? ❑ Yes ❑ No If yes: ❑ Bladder ❑ Bowel Is catheterization needed? ❑ Yes ❑ No
Please provide any additional information (developmental, social, behavioral) for consideration: _____
_____

Permission to use photographs, video tape and/or audio tape of you and/or your family

On behalf of myself and my family, I do hereby give Camp Sunshine, without consideration or compensation, permission to use photographs, videotape, and/or audiotape that may be taken or recorded while my child and family are attending Camp for promotional, educational, or fundraising activities. It is my understanding that these likenesses may be used to promote public and professional understanding and support of the program. I waive any right that I may have to inspect or approve the finished product or the use to which it may be applied.

Parent/Guardian/Other Adult _____ Signature _____ Date_____
(please print)

Parent/Guardian/Other Adult _____ Signature _____ Date_____
(please print)

Permission to use photographs and/or videotape of you and/or your family for postings on Social Media

On behalf of myself and my family, I do hereby give Camp Sunshine, without consideration or compensation, permission to use photographs and/or videotape that may be taken or recorded while my child and family are attending Camp for postings on social media, including but not limited to postings on Camp Sunshine at Sebago Lake's official Facebook page. I waive any right that I may have to inspect or approve the finished product or the use to which it may be applied.

Parent/Guardian/Other Adult _____ Signature _____ Date_____
(please print)

Parent/Guardian/Other Adult _____ Signature _____ Date_____
(please print)

Permission to use family name in connection with fundraising efforts

I give my permission for Camp Sunshine to use my/my family's name to help raise funds for a Family Sponsorship. I understand that I am to receive no compensation for the use of my/my family's name for these purposes.

Parent/Guardian/Other Adult _____ Signature _____ Date_____
(please print)

Parent/Guardian/Other Adult _____ Signature _____ Date_____
(please print)

AUTHORIZATION FOR CAMP SUNSHINE TO PROVIDE MEDICAL TREATMENT

I hereby give my consent for Camp Sunshine's medical personnel to provide any and all reasonable and necessary medical treatment for my children.

(Please include all of the children in your family who will be attending Camp Sunshine.)

All Children's Names	Date of Birth
1.	
2.	
3.	
4.	
5.	
6.	
7.	

This authorization shall remain in effect while we are attending Camp Sunshine at Sebago Lake in Casco, Maine.

Parent/Guardian/Other Adult _____ Signature _____ Date_____
(please print)

Parent/Guardian/Other Adult _____ Signature _____ Date_____
(please print)

I understand and agree that information disclosed regarding any of the individuals named in this application and related documents may be disclosed or otherwise released to appropriate organizations or individuals (including, but not limited to: members of the Camp Sunshine staff, area hospitals, health care professionals and physicians) in connection with attendance at Camp Sunshine at Sebago Lake, Inc. I hereby confirm that the above information is true and accurate and that once accepted, I agree to update this information as may be requested.

I understand that Camp Sunshine reserves the right to accept or decline any application for any reason.

Parent/Guardian/Other Adult _____ Signature _____ Date_____
(please print)

Parent/Guardian/Other Adult _____ Signature _____ Date_____
(please print)

Physician Guidelines for Camp Sunshine

The medical guidelines for patients who wish to attend Camp Sunshine are as follows:

1. Children are considered medically acceptable to participate in the program if they can be expected to be in good general health at the time of the camp session. Children should not attend camp if they are entering into an anticipated period of significant myelosuppression. We regret that we cannot accommodate patients with renal disease who are on hemodialysis.

2. Children should undergo laboratory testing, when appropriate, prior to attending Camp. A "Late Changes" form is to be sent to camp 1-3 weeks in advance of the child's attendance if there has been a change in clinical status or medication regimen.

3. The Physical Examination form must be completed by the child's subspecialty team and returned along with the child's application.

4. Children should not require any therapy during Camp other than treatment usually administered by parents, with the exception of methotrexate or colony stimulating factors.

5. Children should not require any form of special medical care during the week of Camp, e.g. transfusions.

6. Arrangements for laboratory investigations at Camp should be made in advance by the referring physician, or by the parents with the camp physician upon arrival.

7. **Children or other susceptible family members who have been exposed to varicella (chickenpox) within three weeks of a camp session cannot attend. In the event that a child or family member has been exposed to herpes zoster (shingles), please contact Camp for further guidance.**

8. **Children or family members who have received oral polio vaccine within six weeks of a camp session cannot attend.**

9. Children must be 18 years of age or younger.

If a child does not meet these guidelines, please contact the Camp Sunshine office directly so the situation can be further assessed.

It is the intent of Camp Sunshine to provide respite for your patients and their families with as little medical intervention as possible. A physician will be present at Camp to provide evaluation of acute problems. No treatment will be offered at Camp other than management of routine childhood illnesses and minor injuries. Transportation will be provided to a nearby medical facility in the event that other treatment is necessary. It is not the intent of Camp Sunshine to provide routine medical care for other family members.

Thank you for helping us to provide a unique respite experience for your patients and their families. It is our expectation that children will be qualified as acceptable for referral by their own treating physicians with the above specifications in mind. Children who do not meet the above guidelines will find it inconvenient to receive needed medical care in this setting and should not be encouraged to attend. Please contact the Family Coordinator with any questions regarding the above or any aspect of medical support available for Camp participants at 207-655-3800 between 8:30am and 4:30pm Monday through Friday.

Please submit a completed application to:
Camp Sunshine
35 Acadia Road
Casco, ME 04015

Phone: (207) 655-3800 Fax: (207) 655-3825
www.campsunshine.org

CAMP SUNSHINE SOLID ORGAN TRANSPLANT PHYSICAL EXAMINATION FORM

The following information should be provided by the pediatric transplant team treating the child.

Please return to Camp Sunshine: 35 Acadia Road, Casco, Maine 04015 P: (207) 655-3800 F: (207) 655-3825

THIS APPLICATION CANNOT BE PROCESSED UNTIL *ALL* THE INFORMATION BELOW IS COMPLETE.

Child's Name: _____ Date of Birth: ____ /____ /____

Diagnosis: _____ Date of Diagnosis: ____/____/____

Allergies: _____ Date of Examination: ____ /____ /____

❶ **Transplant history**

Nature of the transplant _____ If liver or kidney, living related donor? ❑ Yes ❑ No

Date(s) of transplant: ____/____/____ Last episode of rejection: ____/____/____

Describe any surgery in the past year: _____

Describe any ongoing infusion protocols: _____

_____

Has the child been under the care of a psychiatrist? ❑ Yes ❑ No Please describe any behavioral, social, emotional, or psychiatric concerns that may affect the child: _____

_____

❷ **Central Venous Access**

Type of access: ❑ External (Broviac/Hickman) ❑ Internal (Portacath/Infusaport/Mediport) ❑ Not applicable

Special instructions regarding central line/port: _____

❸ **Is the Child Permitted to Participate in the Following Activities at Camp:**

Swim in a chlorinated indoor heated pool? ❑ Yes ❑ No

Swim in lake water? ❑ Yes ❑ No

Engage in contact sports? ❑ Yes ❑ No

Are there any restrictions or suggestions for this child? _____

_____

Describe any disability or physical limitation affecting other camp activity: _____

❹ **Varicella (If the following information is not complete, this application cannot be reviewed.)**

Please indicate:

_____ (1) This child is **IMMUNE** to varicella by reason of (check one or more):

❑ clinical disease (varicella, zoster) ❑ positive titer ❑ Varivax vaccine **– OR –**

_____ (2) This child is **NOT IMMUNE** to varicella and the vaccine has not been administered to him/her.

IN THE EVENT OF A VARICELLA EXPOSURE AT CAMP, WILL THIS CHILD REQUIRE VARIZIG AND/OR ACYCLOVIR? ❑ YES ❑ NO

❺ **EBV/CMV**

(1) This child is seropositive for EBV. ❑ Yes ❑ No Describe any ongoing problems: _____

_____

(2) This child is seropositive for CMV. ❑ Yes ❑ No Describe any ongoing problems: _____

_____

(3) Is there ongoing PTLD? ❑ Yes ❑ No Please describe: _____

_____

❻ PHYSICAL EXAMINATION

Height: _____ Weight: _____ Pulse: _____ Respirations: _____ BP: _____/_____

Please note all abnormal findings. Check "√" indicates normal.

HEENT _____ Musculoskeletal/Back _____

Neck _____ Genitalia _____

Lungs _____ Neurologic _____

Heart _____ Skin _____

Abdomen _____ Prostheses? _____

Comments: _____

❼ LABORATORY INVESTIGATIONS

Date: _____ H/H _____/_____ WBC _____ (ANC _____) Platelets _____

Chemistries: _____ Urinalysis:_____

Will the child require laboratory tests while at camp? If so, please specify which tests and to whom results should be called/forwarded. (Please limit these to essential studies.) _____

❽ MEDICATIONS*

WITH THE EXCEPTION OF WEEKLY METHOTREXATE, CHEMOTHERAPY IS NOT ADMINISTERED AT CAMP.

Please list medications that the child receives routinely (include pain management). Attach additional pages if necessary.

Medication	Dose	Route	Frequency

*Each family should bring all medications, catheter dressings, and other supplies necessary for their child while at camp.

☞ **IS THERE ANYTHING ELSE WE SHOULD KNOW THAT WOULD BETTER ASSIST US IN PREPARING FOR THIS FAMILY TO ATTEND CAMP? IN PARTICULAR, ARE THERE ANY SOCIAL OR EMOTIONAL CONCERNS PERTAINING TO ANY FAMILY MEMBER?** _____

_____

We regret that applications cannot be reviewed unless the signature of the attending pediatric transplant physician or nurse practitioner is provided below. Thank you.

I have examined _____ who is physically able to engage in camp activities except for the limitations and restrictions noted above.

Attending physician/nurse practitioner signature: _____ Date _____
Type/print name: _____
Address: _____
Telephone: (_____) _____ Fax: (_____) _____
Telephone or pager where a physician who is familiar with the child can be contacted at night and on weekends: (_____) _____

☞ **PLEASE NOTIFY US OF ANY LAST-MINUTE CHANGES (I.E., MEDICATIONS, LAB RESULTS) ON A LATE CHANGES FORM.** ☜

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Health History Form

Please complete pages 1 and 2 of this form for each person attending. Information must be filled out by a parent/guardian for all minors. Any changes to this form should be provided to Camp Sunshine staff prior to arrival.

Name _____ Birth date _____ Age: _____ Gender: _____

Parent/guardian (if applicable) _____

Name (in full) as you would like it to appear on the nametag _____

Address _____ City _____ State _____ Zip _____

Insurance Information
Is the participant covered by family medical/hospital insurance? ❑ yes ❑ no
Carrier or plan name _____ Policy No. _____ Group No. _____

Medications
Please list all medications taken routinely. Bring enough medication to last the entire camp session. Keep all medication in original packaging/bottle that identifies the prescribing drugs.

Med #1_____Dosage_____Specific times taken each day_____
Reason for taking_____

Med #2_____Dosage_____Specific times taken each day_____
Reason for taking_____

Med #3_____Dosage_____Specific times taken each day_____
Reason for taking_____

General Questions (Explain "yes" answers)

1. Have you had any recent injury, illness, or infectious disease?	❑ yes	❑ no
2. Do you have a chronic recurring illness/condition?	❑ yes	❑ no
3. Have you ever been hospitalized?	❑ yes	❑ no
4. Have you ever had surgery?	❑ yes	❑ no
5. Have you ever had a head injury?	❑ yes	❑ no
6. Have you ever been knocked unconscious?	❑ yes	❑ no
7. Have you ever passed out during exercise?	❑ yes	❑ no
8. Have you ever been dizzy during exercise?	❑ yes	❑ no
9. Have you ever had a seizure?	❑ yes	❑ no
10. Have you ever had chest pain during or after exercise?	❑ yes	❑ no
11. Have you ever had high blood pressure?	❑ yes	❑ no
12. Have you ever been diagnosed with a heart murmur?	❑ yes	❑ no
13. Do you have diabetes?	❑ yes	❑ no
14. Do you have asthma?	❑ yes	❑ no
15. Have you ever had an eating disorder?	❑ yes	❑ no
16. Have you ever had emotional difficulties for which professional help was sought?	❑ yes	❑ no

Please explain "Yes" answers, noting the number of the questions: _____
_____
_____
_____
_____

Name _____

Allergies **Describe reaction and management of the reaction**

Medication allergies (list)

_____ _____
_____ _____
_____ _____
_____ _____

Food allergies (list)

_____ _____
_____ _____
_____ _____
_____ _____

Other allergies (list)

_____ _____
_____ _____
_____ _____
_____ _____

Dietary Restrictions

❑ Does not eat pork ❑ Does not eat eggs ❑ Does not eat dairy
❑ Other (describe) _____

Explain any restriction to activities (e.g. what cannot be done, what adaptation or limitations are necessary)
_____
_____

Use this space to provide any additional information about participant's behavior and physical, emotional, or mental health about which camp should be aware:_____
_____
_____
_____

To the best of your knowledge, which of the following has the participant had?
❑ Chickenpox ❑ Measles ❑ German Measles ❑ Mumps ❑ Hepatitis A ❑ Hepatitis B
❑ Hepatitis C TB Mantoux Test Result: ❑ Positive ❑ Negative

Name of family physician: _____ Phone_____
***(YOU DO NOT NEED A PHYSICIAN'S SIGNATURE)**

Parent/Guardian/Adult Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities as noted.

I hereby give permission to Camp Sunshine's medical personnel to provide any and all reasonable and necessary medical treatment for the person herein described. I further understand and consent that I am responsible for all medical expenses incurred by Camp Sunshine on behalf of the person herein described.

Signature of custodial parent/guardian or adult camper _____
Printed Name _____ Date _____