



## SIBLING APPLICATION

Date Received: \_\_\_\_\_  
(for office use only)

Please complete the entire application and return it to our foundation office. This is a cost-free camp for children who have a brother, sister or parent with cancer. Transportation arrangements and expenses are the responsibility of the participant and his/her family. Please call (406) 549-5987 with questions. Please send completed application to address / fax number / e-mail listed below.

Participant Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male  Female

Name of Cancer Patient: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

Date of Cancer Patient's Diagnosis: \_\_\_\_\_ What is their current status? \_\_\_\_\_

Has this cancer patient attended Camp Mak-A-Dream before? Yes  No  If yes, when? \_\_\_\_\_

### EMERGENCY CONTACT (must be parent or legal guardian)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different than above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Cell ( \_\_\_\_\_ ) \_\_\_\_\_ Phone #2 ( \_\_\_\_\_ ) \_\_\_\_\_ Home  Work

Email: \_\_\_\_\_

### If primary Emergency Contact above cannot be reached, please list secondary contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell ( \_\_\_\_\_ ) \_\_\_\_\_ Phone #2 ( \_\_\_\_\_ ) \_\_\_\_\_ Home  Work

### CAMP SESSION (See Program Schedule at [www.campdream.org](http://www.campdream.org) for list of sessions, dates and ages)

Date of camp session participant is applying for: \_\_\_\_\_

Has participant been to Camp Mak-A-Dream before? Yes  No  If yes, number of times: \_\_\_\_\_

How did you hear about Camp?  Internet  Another Participant  Medical Center  Other \_\_\_\_\_

### INSURANCE INFORMATION (Please include a copy of participant's insurance card with application.)

To be used for special tests, treatments, X-Rays or medical consultations in the event any are needed.

Name of Insurance Company: \_\_\_\_\_

Name of parent who insures child: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Policy Number: \_\_\_\_\_

If Group insurance, company name: \_\_\_\_\_ Group # : \_\_\_\_\_

If Medicaid, indicate number: \_\_\_\_\_ (form continued on next page)

## SIBLING CAMP APPLICATION

Page 2

### **CONSENT AGREEMENT, AUTHORIZATION AND RELEASE**

This Consent agreement, Authorization and Release must be read and signed for the participant to be eligible to attend Camp Mak-A-Dream. For participants under the age of 18, form must be completed and signed by a parent or legal guardian. Participant's full name (printed): \_\_\_\_\_

### **RELEASE OF LIABILITY**

The undersigned understands that occasionally accidents occur during camp activities and that participants may sustain serious personal injury and property damages as a consequence thereof. Knowing the risks of camp activities, nevertheless, and in consideration of the participant's acceptance for participation at camp, the undersigned hereby agrees to assume those risks and to hold harmless the Children's Oncology Camp Foundation, and all camp agents, representatives, employees, and volunteers, from any and all liability, claims for personal injury and/or property damage, costs, expenses, and damages arising out of or connected in any way with the participant's participation in camp activities. Further, the undersigned acknowledges that Camp Mak-A-Dream accepts no responsibility for the loss, damage, or theft of personal property.

### **CONSENT FOR MEDICAL TREATMENT**

The undersigned hereby grants permission to the medical staff or consulting physicians at Camp Mak-A-Dream to administer medication and provide medical care, including any medical emergency care required, and any emergency transportation deemed necessary.

### **PHOTO AND INFORMATION RELEASE**

The undersigned gives Camp Mak-A-Dream permission to photograph and use pictures or visual and audio recordings of the participant in professional and fundraising and/or marketing activities. On occasion, with this permission, participant photographs may be included in a bulletin board, video, website(s), newsletter, camp album, or in personal photographs. The camp respects the privacy of its participants and does not allow unauthorized visitors to photograph the camp or participants.

In addition, by signing below, the undersigned gives Camp Mak-A-Dream the permission to give the participant's contact information to groups or individuals wishing to support Camp Mak-A-Dream by sending them an invitation to an event or by sending information related to camp. This **will not** be a list sold or given to anyone else for any other reason.

### **PARTICIPATION CONSENT**

The undersigned gives permission for the participant to participate in any and all activities, including transportation to and from camp for camp activities, except those specifically prohibited by participants' physician or parent/guardian listed below.

X \_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date



# SIBLING PHYSICAL EXAM FORM

Participant Name: \_\_\_\_\_

A Parent/Guardian should complete the top portion of this form and the participant's physician the lower half.

## SHARING OF MEDICAL INFORMATION

I give permission for my child's physician(s) to provide medical information directly to Camp Mak-A-Dream.

X \_\_\_\_\_  
Signature of Parent / Guardian Date

## SIBLING'S EXAMINATION RECORD Health History (please check all that apply):

- |   |   |   |
|---|---|---|
| <u>Disease</u>                          | <u>Allergies</u>                        | <u>Chronic or Recurring Illness</u>     |
| <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Hay Fever      | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Measles        | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Heart Disease  |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Drugs          | <input type="checkbox"/> Convulsions    |
| <input type="checkbox"/> Mumps          | <input type="checkbox"/> Insect Stings  | <input type="checkbox"/> Diabetes       |
|   | <input type="checkbox"/> Ivy, Oak, etc. | <input type="checkbox"/> Behavior       |
|   | <input type="checkbox"/> Foods: _____   |   |

Participant's immunizations are current:  Yes  No If no, explain: \_\_\_\_\_

Operations or serious injuries (dates): \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Other diseases or details of above: \_\_\_\_\_

Please make any necessary comments regarding the following:

Fainting _____	Sleep Disturbances _____
Bed Wetting _____	Menstruation _____
Constipation _____	Other _____

Specific activities to be restricted (if any): \_\_\_\_\_

Special medical or dietary regimen to be followed (specify): \_\_\_\_\_

## PHYSICAL EXAMINATION *(the section below is to be filled out & sent in by participant's physician)*

Physical exams must be completed within six months of camper's attendance of camp.

Name of Physician: \_\_\_\_\_ Medical Center / Clinic: \_\_\_\_\_

Date of Examination: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_

Appearance/Nutrition: Code: Satisfactory (/) Not Satisfactory (x) Not Examined (o)

Ears - Hearing (right) _____	(left) _____	Musculoskeletal _____
Nose _____	Abdomen _____	Teeth _____
Throat _____	Genitalia _____	Hernia _____
Heart _____	Skin _____	Lungs _____

X \_\_\_\_\_  
Physician Signature Date