Piedmont Health Services and Sickle Cell Agency

SUMMER ENRICHMENT CAMP

P. O. Box 20964, Greensboro NC 27420
(336) 274-1507 or 1-800-733-8297
Fax: (336)275-7984

Camper Application

Application must be completed and signed by a Health Care Provider (Pediatrician, Hematologist, Nurse Practitioner, or Physician Assistant)

****PLEASE NOTE: COMPLETED APPLICATIONS ARE APPROVED ON A FIRST COME, FIRST SERVED BASIS. TO ASSURE YOUR RESERVATION, SEND YOUR COMPLETED APPLICATION IN AS SOON AS POSSIBLE.***

PLEASE PRINT OR TYPE APPLICATION **DATE** _____

NAME: _____ **DOB:** _____/_____/_____ **AGE:** _____ **SEX:** _____
LAST FIRST MIDDLE

MAILING ADDRESS: _____
STREET CITY STATE ZIP code

COUNTY OF RESIDENCE: _____ **CURRENT GRADE LEVEL:** _____

PARENT/LEGAL GUARDIAN: _____

PHONE: _____ **WORK:** _____ **EMAIL:** _____

PERSON TO BE NOTIFIED IN AN EMERGENCY IF PARENT/GUARDIAN CANNOT BE REACHED:

NAME: _____ **RELATIONSHIP:** _____

PHONE: _____ **ALTERNATE PHONE:** _____

HEALTH INSURANCE INFORMATION:

COMPANY _____ **POLICY NUMBER** _____

TRANSPORTATION TO & FROM CAMP PROVIDED BY _____

IF A REQUEST FOR CAR POOLING IS RECEIVED, MAY WE GIVE YOUR NAME & PHONE NUMBER TO OTHERS?_____

HAVE YOU ATTENDED SICKLE CELL SUMMER ENRICHMENT CAMP BEFORE? _____ **WHEN?** _____

T-SHIRT SIZE (Check one)

☐ **Youth Medium** ☐ **Youth Large** ☐ **Adult Small** ☐ **Adult Medium** ☐ **Adult Large** ☐ **Adult X-Large**

HOW DID YOU FIND OUT ABOUT SICKLE CELL SUMMER ENRICHMENT CAMP?

_____

_____

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IMPORTANT NOTE: THE NEXT SECTION MUST BE SIGNED BY PARENT OR GUARDIAN.

APPLICANT'S NAME _____

RELEASE OF INFORMATION: I hereby give permission to Piedmont Health Services and Sickle Cell Agency (PHSSCA) to release or receive information, on the applicant named above, to and from other related professionals and agencies, as necessary for the purpose of serving the client, and with the understanding that such information will be held confidential. I also give permission for PHSSCA to gather information for the purposes of evaluating the camp experience for above named child. Failure to complete this information will have no bearing on my child attending camp.

CAMP ATTENDANCE RELEASE: I hereby give permission for the applicant as named above to attend Sickle Cell Summer Enrichment Camp at Camp Carefree.

In consideration for the acceptance of the above named, I/we hereby release any claim or cause of action which may accrue against the PHSSCA and/or Camp Carefree, and any employee or either one and any other person acting with the permission of either, arising out of any injury acquired during his/her stay at the camp, in transit to and from said camp, or during any activity approved by any of said persons. I/we agree to assume any claim which said child in his/her personal capacity might have against any of said persons for injury as herein stated.

Signature of Parent/Guardian _____ Date: _____

PHOTO RELEASE: I consent to the use and publication by PHSSCA and/or Camp Carefree, its affiliates or others with its consent, of any photographs, negatives, prints, motions pictures, video tapes, pictures on Facebook, or other similar reproductions obtained of the applicant as named above while participating in any camping activity through any medium of communication.

Signature of Parent/Guardian _____ Date: _____

Piedmont Health Services and Sickle Cell Agency
Assumption of Risk and Waiver of Liability Relating to COVID-19

The novel coronavirus ("COVID-19") has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people. Piedmont Health Services and Sickle Cell Agency has put in place preventative measures to reduce the spread of COVID-19; however, we cannot guarantee that you or your child(ren) will not become infected with COVID-19. Further, attending the Sickle Cell Summer Enrichment Camp could increase your child(ren)'s or your risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by COVID-19 by attending the Sickle Cell Summer Enrichment Camp and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at the Camp may result from the actions, omissions, or negligence of myself and others, including, but not limited to, staff, counselors, volunteers, and program participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s attendance at the Sickle Cell Summer Enrichment Camp or participation in programming ("Claims"). On my behalf, and on behalf of my children, I hereby release, covenant not to sue, discharge, and hold harmless Piedmont Health Services and Sickle Cell Agency and the Board of Directors their current, former, and future agents, representatives, and employees and related entities of and from the Claims, including all liabilities, claims, actions, damages, costs, or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of Piedmont Health Services and Sickle Cell Agency, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any Sickle Cell Summer Enrichment Camp.

_____	_____
Signature of Parent/Guardian	Date
_____	_____
Print Name of Parent/Guardian	Name of Student Participant(s)

HEALTH HISTORY/EMERGENCY TREATMENT RELEASE
To be completed by parent or guardian
PHONE: (336) 274-1507 1-800-733-8297 Fax: (336) 275-7984

PLEASE ANSWER ALL QUESTIONS:

Camper Name _____ Birth Date _____

Hemoglobin Type: _____ SS _____ SC _____ S-Thal _____ Other_____

Parent or Guardian _____ Phone _____

Allergies (i.e., foods, drugs, insect bites, etc.) _____

_____

Dietary Restrictions (if any): _____

Other Medical Conditions (i.e., asthma, diabetes, seizures, heart conditions, etc.)

_____

Please list any physical restrictions or limitations to an activity (i.e., no contact sports, uses walker, etc.):

_____

Immunization Record and COVID-19 Vaccination Record-ATTACH COPY

Date of last hospitalization; please specify reason for admission: _____

Please list name of medicine, dose and time schedule:

Medicine	Dosage	Frequency/Time Schedule

EMERGENCY TREATMENT RELEASE:

Name of Camper: _____

This health history is correct as far as I know, and the above named person has permission to engage in all prescribed camp activities except where noted. I hereby give permission to the camp:

1. **To provide ongoing health care**
2. **To select medical personnel and to order x-rays or routine tests or treatment for the camper.**

In the event I cannot be reached in an emergency, I hereby give permission to the appointed medical director or camp physician to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the above named person. This form may be photocopied for use out of camp.

Signature of Parent/Guardian_____ Date: _____

PIEDMONT HEALTH SERVICES AND SICKLE CELL AGENCY
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CAMP HEALTH FORM

Note: This form must be completed and signed by a physician prior to admission to camp. Campers must have a physical examination within 6 months prior to the camp session. Attach a copy of latest progress notes and immunization record.

NAME: _____DOB: _____/_____/____ Age_____ Sex _____ DATE: ____/____/____

Mailing Address: _____
Street City State Zip

Legal Parent (s)/Guardian: _____ Phone #: _____

Height _____ Weight _____ Blood Pressure _____

Hemoglobin Type: ☐SS ☐SC ☐S/Thal ☐Other _____ Baseline Hemoglobin: _____

Other Health Diagnosis: _____

Significant Findings on Physical Exam:
_____

_____

Past Medical History:
_____

_____

General Appearance: _____

Recent Crisis: ☐Yes ☐No Date: _____ Type: _____

Drug and other Allergies (drugs, food, insect stings, other):
_____

_____

Medical action plan specific to disease or allergy:
_____

_____

_____

Has the camper tested positive for MRSA or VRE? ☐Yes ☐No Date cleared: _____

Menstrual Period: ☐Yes ☐No ☐NA (note special problems) _____
_____

Is the child cognitively appropriate for his/her age? _____ Yes_____ No If no, explain approximate level of functioning:

_____

_____

Describe any additional current medical problems or relevant psychosocial information including any behavior problems that might affect the child's participation in a group and overnight camp setting:

_____

_____

Does child require special medical treatment or other special assistance during camp experience? (oxygen, assistive devices)
Explain:_____

_____

Please list all medications to be administered during camp:

Name of Drug	Dosage	Frequency

Physician Statement: I have examined _____and find him/her physically able to attend camp. I understand the above medical regimen indicated will be followed while he/she is at camp.

Comments or special instructions:
_____

_____

_____

Physician's Name (Type or Print)_____Date_____

Name of Practice or Hospital Affiliation:_____

Physician's Signature__________

Address _____City _____ State _____ Zip _____

Phone _____ Fax_____