

## HFA 2008 Teen Connection Heifer Ranch Camp - Indemnification

**PARENTS/GUARDIANS ARE RESPONSIBLE FOR COMPLETING THIS AND ALL APPLICATION FORMS, INCLUDING THE ATTACHED PARENT'S MEDICAL HISTORY FORM, AND RETURN THEM TO THE HEMOPHILIA FEDERATION OF AMERICA'S OFFICE NO LATER THAN April 1, 2008.**

The undersigned parents or guardians of the following child apply for admission of their child to a Weekend Camp for 1 ½ days, sponsored by the Hemophilia Federation of America (HFA) and Global Health Society (GHS). The camp will be held at Heifer Ranch, located outside of Little Rock, Arkansas, Friday, May 2, 2008, through Saturday, May 3, 2008.

\*Parents and/or guardians shall be responsible for getting their child(ren) to the bus pick-up locations at the Peabody Little Rock Hotel, as described further in a separate enclosure that the families will receive with their confirmations.

\*The HFA and GHS shall furnish shelter, meals, supervised activities and basic medical care without charge to campers or their families while the child is at camp.

\*Parents/guardians will be responsible for providing their child with suitable clothing and personal care items, as outlined in a separate enclosure.

\*Neither HFA, nor GHS, nor Heifer Ranch shall be responsible for any possessions the campers bring to camp, such as flashlights, cameras, sports equipment, clothing, jewelry, etc.

\*Parents/guardians shall be responsible for advising the **Hemophilia Federation of America and Global Health Society** if their child has been exposed to chicken pox, measles, German measles, or mumps within the three-week period prior to May 2, 2008.

\*Supervised activities planned during the camp include: challenge ropes course, limited hiking, & arts and crafts. It is understood that the camp doctor(s) and/or nurse(s) may exclude a child from any activity which could be dangerous to the child's health.

\*Parents/guardians, by signing this form, give permission to the camp doctor(s) and nurse(s) to treat the child for any medical condition which may arise during camp; they further give permission for the camp doctor(s) and nurse(s) to treat any pre-existing condition in accordance with the child's doctor's treatment plan, as indicated on the Medical History form. Campers who are capable of infusing themselves will be encouraged to do so.

\*The camp doctor(s) will release information concerning any medical treatment which was required by the child at camp to the doctor who completes the attached Medical History Form.

\*The camp doctor(s) and Heifer Ranch will arrange suitable medical care in the event of any medical emergency which cannot be treated at camp. Parents/guardians, by signing this form, give permission to the camp doctor(s) to employ such medical and hospital care and services, including ambulances and/or helicopters, if necessary, in the event of an emergency. Parents/guardians will make arrangements for reimbursement of any emergency hospital or ambulance charges through their private insurance and/or Arkansas Children's Services.

\***CONSENT TO PHOTOGRAPH:** I/We hereby authorize the Hemophilia Federation of America and Global Health Society to photograph the above named minor in connection with his/her presence at Heifer Ranch. The photograph(s) may appear in hospital, HFA, GHS, and/or public newspaper camp publicity.

**IF YOU DO NOT AGREE TO THE PHOTOGRAPH CONSENT PART OF THIS FORM, YOU WILL NEED TO WRITE A LETTER TO THE HFA REQUESTING THAT NO PHOTOS OF YOUR CHILD BE TAKEN SO WE MAY FILE IT WITH YOUR CHILD'S FORMS.**

\*CONSENT FOR EDUCATIONAL PROGRAMS: I/We hereby give consent for my child to participate in any educational sessions offered at the HFA/GHS weekend camp. This consent includes planned HIV/AIDS and age appropriate sex education programs for the older campers (16-18) and general hemophilia education for the younger campers (12-15). I understand that if my child does not participate in the planned education program, he/she will be offered an alternative activity.

PARENTS MUST INITIAL ONE OF THE FOLLOWING:

\_\_\_\_ I consent to the educational programs for my child(ren)

\_\_\_\_ I DO NOT consent to the educational programs described above and ask for alternate activity for my child(ren)

I/We agree to hold harmless, indemnify and forever discharge the Hemophilia Federation of America, Global Health Society, Heifer Ranch, their employees or agents any claims which may arise as a result of or in connection with the participation of the child in this camp or its activities. This includes and representatives acting on my behalf or on the behalf of my estate.

**I/we have read all of this camp application and agree to its terms.**

X \_\_\_\_\_  
Signature of parent/guardian Date

X \_\_\_\_\_  
Signature of parent/guardian Date

Print parent(s)/guardian(s) \_\_\_\_\_ Names \_\_\_\_\_ of \_\_\_\_\_

## CAMP POLICY STATEMENT

Our weekend camp for children with bleeding disorders is a new idea that we hope you will embrace. We have established an environment that builds self-esteem and support, and rewards persons for their effort. We are a community and family during any of the programs we provide for the participants.

Within any community the right to participate comes with responsibilities to the group and the program. All HFA/GHS programs emphasize respect for each other and the environment. Participants who are unable to live within the limits may be disciplined in several ways.

- a. Counselors will reinforce the limit and ensure that the participant understands the expectation.
- b. Participants may be excluded from popular activities for a limited period of time.
- c. Methods of conflict resolution, values clarification and mediation may be utilized when conflict arises between participants.
- d. General maintenance or other chores that benefit the camp environment may be utilized.

Our goal is to assist the participant to have the best possible experience in our programs. ***Dismissal from the program will be a last resort. DISMISSAL SHALL BE IMMEDIATE should the following rules be violated:***

- 1. POSSESSION AND/OR USE of alcohol or illegal/non prescribed drugs.
- 2. Serious threats of physical harm or revenge directed at any other participant.
- 3. Striking any staff person.
- 4. Fighting that results in bleeding or harm to any camper or oneself.
- 5. Theft or destruction of property. Parents are responsible for any damaged camp property.
- 6. Disruptive behavior during transport to or from the program.

PLEASE REVIEW THESE ISSUES WITH YOUR CHILD. BOTH CAMPER AND PARENT/GUARDIAN SHOULD SIGN BELOW INDICATING AGREEMENT TO THESE POLICIES.

I HAVE READ, UNDERSTOOD AND AGREE TO THE ABOVE-NAMED POLICIES:

X \_\_\_\_\_  
Camper's Signature Date

X \_\_\_\_\_  
Parent's or Guardian's Signature Date

**THIS APPLICATION MUST BE SIGNED BY BOTH THE CAMPER AND ONE PARENT/GUARDIAN AND RETURNED TO THE HEMOPHILIA FEDERATION OF AMERICA NO LATER THAN April 1, 2008.**

**Form #2- Physician's Form**

*This form is to be filled out by the child's doctor.*

*Parents: Please send this form to your child's doctor immediately!*

*Doctor: This Form must be completed and returned to the HFA office  
April 1, 2008*

NAME OF CHILD \_\_\_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_

DATE OF LAST PHYSICAL EXAM \_\_\_/\_\_\_/\_\_\_ WEIGHT \_\_\_\_\_kg

Diagnosis (please check): Factor VIII deficiency \_\_\_\_\_ Factor IX deficiency \_\_\_\_\_  
von Willebrand disease (type) \_\_\_\_\_  
Other factor deficiency (type) \_\_\_\_\_  
Platelet dysfunction (type) \_\_\_\_\_  
  
Factor Activity Level \_\_\_\_\_%  
Inhibitor? Yes \_\_\_ No \_\_\_ Inhibitor Titer \_\_\_\_\_  
Date of last inhibitor test \_\_\_/\_\_\_/\_\_\_  
Immune Tolerance? \_\_\_\_\_

	<b>Normal</b>	<b>Abnormal</b>	<b>Explain Abnormalities</b>
Head & Neck	_____	_____	_____
Eyes & Ears	_____	_____	_____
Nose & Throat	_____	_____	_____
Dental	_____	_____	_____
Chest	_____	_____	_____
Heart	_____	_____	_____
Abdomen	_____	_____	_____
Extremities	_____	_____	_____
Neurological	_____	_____	_____
Skin	_____	_____	_____
Psychological	_____	_____	_____

Major sites of hemorrhages during the past year: \_\_\_\_\_

Any current additional medical or dental problems?  
\_\_\_\_\_

Significant past medical history:  
\_\_\_\_\_

List any surgical procedures and dates:  
\_\_\_\_\_  
\_\_\_\_\_

**Signature of Doctor:**  
X \_\_\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_

Name of Doctor  
(Printed): \_\_\_\_\_  
Address \_\_\_\_\_

Phone No: (\_\_\_\_) \_\_\_\_\_ Fax No. (\_\_\_\_) \_\_\_\_\_

**Please return by April 1, 2008 to: (Fax) 1-337-261-1787 or c.lancon@hemophiliafed.org  
Hemophilia Federation of America, 1405 W. Pinhook Rd., Suite 101, Lafayette, LA 70503.**

**Hemophilia Federation of America**  
**Form #3 - MEDICAL FORM FOR PARENT/GUARDIAN**  
*To be filled out COMPLETELY by a parent or guardian and returned to HFA no later than April 1, 2008*

1. Camper's Name \_\_\_\_\_

2. Address \_\_\_\_\_

3. City, State, ZIP \_\_\_\_\_

4. Date of Birth \_\_\_\_\_ 5. Weight \_\_\_\_\_ 6. Grade in Sept \_\_\_\_\_

7. Parents'/Guardians' Names & Telephone Numbers:

Parent #1: Name: \_\_\_\_\_ day ( ) evening ( ) cell phone ( ) \_\_\_\_\_

Parent #2: Name: \_\_\_\_\_ day ( ) evening ( ) cell phone ( ) \_\_\_\_\_

Guardian: Name: \_\_\_\_\_ day ( ) evening ( ) cell phone ( ) \_\_\_\_\_

8. Hemophilia Treatment Center \_\_\_\_\_ Phone Number \_\_\_\_\_

9. Primary Physician's Name \_\_\_\_\_ Phone Number: \_\_\_\_\_

**10. Insurance Carrier Name** \_\_\_\_\_

**Policy #** \_\_\_\_\_ **Group #** \_\_\_\_\_ **Primary Insured Name:** \_\_\_\_\_

11. Product usually used to treat a bleed \_\_\_\_\_ Usual Dose \_\_\_\_\_

Has your child ever had an allergic reaction to a factor product? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, what product? \_\_\_\_\_ What kind of reaction? \_\_\_\_\_

12. Is your child treated on a regular basis (prophylaxis)? Yes \_\_\_ No \_\_\_

Which days of the week (e.g. every other day or Monday-Wednesday-Friday) \_\_\_\_\_

Will your child be treated before he gets on the bus to come to camp? YES \_\_\_\_\_ NO \_\_\_\_\_

13. Where does your child usually bleed? \_\_\_\_\_

14. How often does your child usually get treated for a bleeding episode? \_\_\_\_\_

(i.e., once/week, once/month, twice/year, etc.)

15. Does your child know how to self-infuse? Yes \_\_\_ No \_\_\_ If not, does he help with mixing? \_\_\_\_\_

Would you like your child to start learning to self-infuse at camp? Yes \_\_\_\_\_ No \_\_\_\_\_

16. Does your child have a port? Yes \_\_\_ No \_\_\_ Broviac? Yes \_\_\_ No \_\_\_

17. Does your child use splints, crutches, wheelchair or any other device? Yes \_\_\_ No \_\_\_

If yes, what does your child use? \_\_\_\_\_

18. Does he/she participate in a regular physical therapy or exercise program? Yes \_\_\_ No \_\_\_

If yes, please provide a copy of the program with this application.

19. Are there any family issues that might affect your child at camp (e.g. recent illness, divorce, death)? \_\_\_\_\_

\_\_\_\_\_

20. Are there any behavior issues we should be aware of (e.g. bed-wetting, anger management, shyness)?

\_\_\_\_\_

**Please attach a copy of your child's immunization record or fill in the blanks below. We need the *actual dates*, not just the words "*up to date*". If you do not have the records at home, please call your doctor's office or child's school for the dates. IF EACH BOX IS NOT FILLED IN, YOUR DOCTOR MUST WRITE THE REASON ON THIS FORM.**

21. DATES OF IMMUNIZATION:

Diphtheria/Pertussis/Tetanus / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ /

Tetanus Booster \_\_\_\_\_ (Child must have had a tetanus shot in the past 10 yrs.)

MMR \_\_\_\_\_ / \_\_\_\_\_ (Two measles shots are needed if child has never had measles.)

Hepatitis A Vaccine \_\_\_\_\_ / \_\_\_\_\_ Hepatitis B Vaccine \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Chicken Pox Vaccine \_\_\_\_\_ or year that s/he had the disease \_\_\_\_\_

22. Please list any medications, other than factor, including vitamins, that your child takes daily. All such medications should be sent to camp in clearly labeled medicine bottles.

Medicine	Dose	# times taken daily	Times of day taken	Reason
1) _____				
2) _____				
3) _____				
4) _____				

23. MEDICATIONS YOUR CHILD TAKES ONLY FOR A SPECIFIC PROBLEM (e.g. Asthma, Allergies, Pain)

Problem	Medicine	Dose	# times/day	Time/day taken	For how many days?
1) _____					
2) _____					
3) _____					
4) _____					

24. Is your child allergic to any medications? Yes \_\_\_ No \_\_\_. If yes, what medication? \_\_\_\_\_  
Type of allergic reaction? \_\_\_\_\_

25. Has your child had any hospitalizations in the past year? Yes \_\_\_ No \_\_\_ If yes, give dates and reason  
\_\_\_\_\_

**I hereby consent for the medical/nursing/physical therapy staff to treat my child for any medical problems that arise at camp or for any chronic medical conditions that my child may have.**

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

**IF HFA DOES NOT RECEIVE A COMPLETE IMMUNIZATION RECORD, YOUR CHILD CANNOT ATTEND HFA TEEN CONNECTION HEIFER RANCH OVERNIGHT CAMP.**

**Please return this form – COMPLETED – to the HFA offices No later than April 1, 2008**

**Hemophilia Federation of America and Global Health Society  
HFA 2008 TEEN CONNECTION HEIFER RANCH CAMP  
AUTHORIZATION FOR  
EMERGENCY MEDICAL TREATMENT**

I hereby give permission for my child, \_\_\_\_\_,  
DOB \_\_\_\_\_, to be given emergency medical treatment as deemed  
necessary by the medical personnel at Heifer Ranch and by the ground and/or  
bus chaperones to and from Camp.

I authorize the release of my child's medical information to emergency  
room personnel as needed to facilitate my child receiving appropriate medical  
care.

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

\_\_\_\_\_  
**PRINTED Name**

\_\_\_\_\_  
**Relationship to Camper**

**Deadline: April 1, 2008**  
**Please Fax, email or mail to:**  
**Hemophilia Federation of America,**  
**attn: Symposium Teen Program,**  
**1405 W. Pinhook Rd, Suite 101,**  
**Lafayette LA 70503**  
**(Fax) 337-261-1787 or c.lancon@hemophiliafed.org**