

Cancer Hope Foundation  
568 Constitution Ave., Unit F  
Camarillo, Ca. 93012

Phone: (805)384-5445  
Fax: (805)384-2203  
www.cancerhopefoundation.org

## Camp Keepsake

A program of **Cancer Hope Foundation**♥  
CAMPER / GROUP APPLICATION 2010

For the purpose of this application, the applicant is the person with or who has had cancer. The camping experience is intended for the campers and up to five additional guests of their choice. These guests can be members of their family, close friends, or caregivers. Please fill in the information for the first 5 pages of the application as completely as possible. If extra space is needed, please simply add additional pages. Please have the main applicant's doctor complete the 6<sup>th</sup> and 7<sup>th</sup> pages (after signing the release at the top of page 6). This application supersedes all prior year's camp applications and must be completed for consideration. This year's camp session will be October 1<sup>st</sup>-3<sup>rd</sup>, 2010. Accepted campers will be extended an invitation. Each session will run from approximately 4pm on Friday through around 1pm on Sunday. We anticipate sending out invitations in August or September.

PLEASE RETURN YOUR APPLICATION AS SOON AS POSSIBLE. Please print or type clearly and write on the reverse or attach additional pages as needed for clarification. Space is limited. A portion or all of our applicants will be considered on a first come/first serve basis; consequently, available openings may be filled prior to our application deadline (which is available on our website). Please note that submitting an application does not ensure an invitation. All completed applications will be reviewed and considered by our selection committee. Selection of applicants for each camp session is solely within the discretion of the selection committee. Each camp session requires a new application. This camp session is primarily geared toward adults who are recently out of treatment or currently undergoing treatment and are still physically able to attend camp; though patients in remission are also encouraged to apply, since we strive to also include some such applicants as well.

ALL INFORMATION IS CONFIDENTIAL TO QUALIFIED CHF VOLUNTEERS.

Applicant Full Name: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Have you attended Camp Keepsake before? If so, what year(s)? \_\_\_\_\_

If we cannot accept your entire party, would you be willing to change your number of guests? \_\_\_\_\_

How did you hear about camp? \_\_\_\_\_

Please indicate primary language spoken? \_\_\_\_\_

Please indicate any special food or other needs of you or any of your desired guests:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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### HEALTH HISTORY

The information below is for the Camp Directors and Medical Staff and is treated in a confidential manner. It will enable us to plan for your needs. Patients/Campers will be responsible for administration of all routine medications and treatments themselves. All medications must be brought with the camper(s) and clearly labeled with the patient's name, drug name, dosage, and times per day taken. Please bring other supplies you may need to camp. If the applicant needs IV therapy or other pre-known medical treatments during camp, this can be considered and perhaps accommodated with prior communication through CHF's Camp Medical Team.

Applicant's Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Grade or Stage: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ Treatment Center: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Is there a central venous access device? (Hickman, Grosong, Port-A-Cath) \_\_\_\_\_

If so, what type: \_\_\_\_\_

Is patient independent with care of line? \_\_\_\_\_

How often do you flush line? \_\_\_\_\_

What kind of dressing is used? \_\_\_\_\_

How often is the dressing changed? \_\_\_\_\_

Have there been any recent problems with the line? \_\_\_\_\_

Is applicant under any type of treatment at this time? \_\_\_\_ Yes \_\_\_\_ No

How would you describe your cancer? Active:\_\_\_\_ Maintenance:\_\_\_\_ Remission:\_\_\_\_ Cured:\_\_\_\_

Date of last chemo and/or radiation treatment:\_\_\_\_\_ What was the therapy/treatment?\_\_\_\_\_

Is there a post-chemo/treatment symptom control regime?\_\_\_\_\_

If/When do you expect the next Nadir? \_\_\_\_\_

Please clearly explain your current condition and history with cancer. For instance, include if you are in remission and if so, for how long? What is your prognosis? Please include any other information you deem helpful to help us clearly understand your condition and history. Please add additional pages if needed.

**Note, this question must be answered.**

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### GROUP HEALTH HISTORY

The following information is treated in a confidential manner, is for the medical and directory staff and must be completed for every member of your group attending:

Name of <u>each</u> camper who will be attending	Immunized?	Date of Last Tetanus Booster	Had Chicken Pox or Vaccine?	Diabetes?	Allergies Yes/No To what?	Asthma?	Prosthesis?

### MEDICATION PROFILE -OTHER THAN CHEMO

Name of each camper who will be attending	Medication	Indication	Dosage	Route	Frequency

Are there any other medical or other conditions of campers in your group that we should be aware of? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is there anything else you feel we should know and/or that we could do to make your camping experience safer and/or more meaningful (any additional information you care to share)? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**IMPORTANT: IF THERE ARE ANY SIGNIFICANT CHANGES TO ANY OF THIS INFORMATION BETWEEN NOW AND CAMP, PLEASE CALL OUR OFFICE AS SOON AS POSSIBLE PRIOR TO CAMP.**

Please return completed forms to the address listed on the top of each page.  
**RELEASE, WAIVER OF LIABILITY, MEDICAL AUTHORIZATION & PHOTO RELEASE**

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**TO BE COMPLETED BELOW BY EACH MEMBER OF YOUR GROUP ATTENDING CAMP**

The undersigned on behalf of him/herself, their agents, heirs and representatives hereby releases, waives, discharges and covenants not to sue Camp Keepsake, Cancer Hope Foundation or any of its affiliates, members of its Board of Directors, employees, agents, contractors, volunteers and all other camp personnel whether volunteers or paid staff, (hereinafter referred to as "Releasees") for any and all liability, claims, demands, damages, causes of action, losses, or expenses (including attorney's fees and expenses) to the undersigned and/or to any minor child being signed for, on account of physical, mental, or emotional injury, or death of the person or minor child or to the property of the person or minor child, *whether such injury or death be caused by the negligence, gross negligence of the Releasees or otherwise, while the person or minor child participates in Camp. Notwithstanding any other provision of this Release and Waiver, the undersigned also releases Cancer Hope Foundation (hereafter "CHF"), but no other Releasee from any liability whatsoever arising from any injury, damage, or death to the person or minor child where said injury, damage, or death is the result of, or arises from any intentional or criminal conduct upon the part of a CHF employee, agent, volunteer, camp counselor, or any other camp personnel.*

The undersigned grants permission for CHF affiliated medical and directorial volunteers to treat and act upon any and all medical conditions as deemed appropriate by them. The undersigned hereby grants Camp Keepsake and/or Cancer Hope Foundation or any of its affiliates, members of its Board of Directors, employees, agents, contractors, volunteers, guests and all other camp personnel, whether volunteers or paid staff, permission to allow, take, release or utilize pictures and/or recordings of an audio or visual nature or both of themselves and/or any minor they are signing for, as deemed appropriate by Camp Keepsake and/or Cancer Hope Foundation for means of public relations, marketing, media or otherwise. The undersigned hereby releases, waives, discharges and covenants not to sue Camp Keepsake nor Cancer Hope Foundation or any of its affiliates, members of its Board of Directors, employees, agents, contractors, volunteers and all other camp personnel whether volunteers or paid staff for any and all liability, claims, demands, damages, causes of action, losses, or expenses (including attorney's fees and expenses) to the undersigned and/or to any minor child being signed for.

The undersigned further expressly agrees that the foregoing release and waiver is intended to be as broad and inclusive as is permitted by the law of the State of California, and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. If a portion of below is incorrectly completed or left blank, any sign of intent to complete will be considered as full and correct completion.

The undersigned has read and voluntarily signs the Release and Waiver of Liability and Photo Release and further agrees that no oral representations, statement or inducement apart from the foregoing have been made, and that this Agreement may only be modified by a written document signed by the undersigned and a duly authorized representative of Cancer Hope Foundation.

Printed name of each possible camper in your party	Signature of self or if signing for a minor, signature of parent or legal guardian	If signing for a minor, please print signor's name	If signing for a minor, indicate Relationship to the minor	Signer's phone number	Date signed

Please return completed forms to the address/fax listed on the top of each page.

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## CAMP KEEPSAKE PHYSICIAN RELEASE FORM

**This integral portion of your application must be fully completed by your oncologist/physician & faxed or mailed to us at one of the above listed numbers ASAP. Please provide your doctor with authorization to complete this form by signing below where indicated. Additionally, your signature below shall serve as authorization for Cancer Hope Foundation to follow up with and retain corresponding information from your doctor and act upon same as deemed appropriate by Cancer Hope Foundation appointed staff.**

*This top portion of this page is to be completed by patient and the remainder by the doctor.*

Name of Patient: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Patient Address: \_\_\_\_\_ Patient Phone #: \_\_\_\_\_

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

By my signature here, I request that you please complete the following medical information and return it to CHF along with copies of any supporting documents you deem necessary to my medical history that may be of consideration with my attending Camp Keepsake. I understand that my signature also provides authorization for your office to communicate with CHF personnel regarding my Camp Keepsake application as well as possible medical treatment at Camp Keepsake.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*

Dear Doctor:

The above named patient wishes to participate in a weekend family camping experience for people with cancer. A medical team which normally includes a Doctor and Nurse or EMT will be available for emergencies. Patients will be responsible for routine medical care. Please provide as full of report as possible on the above patient using this form in order to help us be apprised of their condition. Camp is available to families (and friends) with an adult cancer patient/survivor. This year's camp session will be October 1<sup>st</sup>-3<sup>rd</sup>, 2010. Please know, campers sleep in cabins and can participate in activities and/or simply relax while taking a break away from their typical daily stresses. Thank you.

Please briefly explain the patient's current condition and history with cancer. For instance, include if they are in remission and if so, for how long? Are they in active treatment? Considered cured? Etc. What is his/her prognosis? Include any other information you deem helpful to help us clearly understand their condition and history. Please use the back side of this form or attach additional pages if needed. Please also fill in the brief clarifying questions below.

Diagnosis: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ Current Grade/Stage: \_\_\_\_\_

Is this patient:	On active chemotherapy?	_____ Yes	_____ No
	On maintenance therapy?	_____ Yes	_____ No
	Post BMT?	_____ Yes	_____ No

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If you responded yes to any of the previous questions, please complete the following questions:

- 1: What agent(s): \_\_\_\_\_
- 2: Is the patient to receive chemotherapy within the two weeks prior to camp? \_\_\_\_\_  
If so, which agent(s): \_\_\_\_\_
- 3: Is Nadir expected? If so, when? \_\_\_\_\_
- 4: Have blood counts been stable on this current therapy? \_\_\_\_\_
- 5: Is this patient using Neupogen/Procrit? \_\_\_\_\_

Other treatment modalities: \_\_\_\_\_

Medications this camper is currently prescribed: \_\_\_\_\_

Date of last evaluation: \_\_\_\_\_

Are there any significant allergies, including bees? \_\_\_\_\_

Does this patient:

- Have seizure activity? \_\_\_\_\_
- Use a prosthesis? \_\_\_\_\_
- Have an unsteady gate? \_\_\_\_\_
- Need durable medical equipment? \_\_\_\_\_
- Have an ostomy? \_\_\_\_\_
- Have eating problems? \_\_\_\_\_
- Need a special diet? \_\_\_\_\_

Does this patient have any other medical conditions we should be aware of? Please be specific:

\_\_\_\_\_

If there are any significant changes to the information provided, please immediately contact:  
our office at (805)384-5445.

**\*\*\*In your medical opinion, is this patient physically and mentally able to participate in a camping program? This question must be answered.**

**YES or NO**

Physician Signature: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Pager: \_\_\_\_\_

If there is an emergency during Camp, how can we best locate you? \_\_\_\_\_

Please return this form via Mail or Fax ASAP. Thank you!!!