

Attention Parents
Important Camp Brave Eagle Registration Information

Dear Parents:

Enclosed is your Camp Brave Eagle 2007 registration packet. In it, you will find:

- A camper packing list – **Page 2**
- IHTC consent and insurance form – **Page 3 - 4**
- Indiana Hemophilia & Thrombosis Center Medical Form – **Page 5 - 10**
- **This must be completed by your primary physician prior to camp!**

PLEASE RETURN THE YMCA CAMP CROSLEY SUMMER CAMP RELEASE, CONSENTS AND INSURANCE, AND THE MEDICAL FORM TO THE IHTC BY *May 18th* The address is: Indiana Hemophilia & Thrombosis Center 8402 Harcourt Road, Suite 500 Indianapolis, In 46260 Attn: Jennifer Maahs

These forms must be completed for each camper. Remember, there are limited spots available so return your forms ASAP.

See You At Camp!

Sincerely,

Jennifer Maahs, MSN, PNP
Hemophilia & Thrombosis Nurse Practitioner

Camp Brave Eagle Camper Packing List

To be well prepared for Camp Brave Eagle, please be sure to pack the following items:

- Factor-approximately 5 infusions
- Medication- any medication (s) taken on a daily basis

Enough clothes for one week, including:

- 1-2 pairs of jeans
- shorts
- tee-shirts
- underwear
- socks (send extra)
- tennis shoes
- sweatshirt
- swimsuit
- flip-flops/sandals & watershoes
- raincoat
- sunglasses
- toothbrush and toothpaste
- soap
- shampoo
- deodorant
- hairbrush
- towels
- pillow
- sleeping bag or sheets & blankets for a twin bed
- insect repellent (no aerosol cans)
- sunscreen
- baseball hat
- waterbottles

Do not bring:

- **No Cell Phones**
- **money,CD players/cassette tape player or iPods**
- **hand held electronic games**
- **food and beverages**
- **weapons of any kind (including camp knives)**

Indiana Hemophilia &Thrombosis Center, Inc.

**Camp Brave Eagle
Consents and Insurance**

SS# _____
Name: _____ Birthdate: _____
Address: _____ Telephone: _____

Parents or Guardians: _____
Address if different than above: _____
Telephone: Work _____ Home: _____ Cell: _____

You Must Indicate Where You Can Be Reached At All Times

MEDICAL CONSENTS FOR TREATMENT AT CAMP BRAVE EAGLE:

I hereby authorize Dr. Amy Shapiro / Anne Greist or any assistants (Nurse Practitioners, nurses, other physicians, etc) as may be designated by her to provide all appropriate medical care for my child, _____, during the annual hemophilia camp, Camp Brave Eagle. The medical care herein authorized shall begin upon arrival at the designated drop off site for transportation to Camp or at Camp Brave Eagle.

I authorize the Medical/HII staff to transport my child in their personal vehicle in case of emergency or for off site activities.

I understand that infusion therapy/DDAVP will be provided as needed at Camp. I understand that treatment for routine illnesses and acute bleeding episodes will be administered as needed at Camp. If a diagnostic procedure, prophylaxis treatment, hospitalization, or other specialized therapy is needed, the costs of such care will be my responsibility.

In addition, I agree to allow my child to participate in the educational portion of Camp, including general hemophilia information, home infusion therapy, social issue discussions, and management of day-to-day living.

Signature of Parent or Legal Guardian Date

PHOTOGRAPHY PERMIT FOR CAMP BRAVE EAGLE:

I hereby authorize permission for the Indiana Hemophilia and Thrombosis Center, Inc (IHTC) and Hemophilia of Indiana, Inc (HII) to take photographs of _____, and/or to release information concerning Camp Brave Eagle. I understand that photographs may be used in the future publicity regarding Camp, in educational sessions, or promotional material of the IHTC.

Signature of Parent or Legal Guardian Date

INSURANCE INFORMATION:

Insurance Coverage:

Policy #: Group #: Name of
Guarantor:

Copy of Insurance Card:

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Indiana Hemophilia & Thrombosis Center, Inc.

Camp Brave Eagle
Medical Information

To Be Completed By Primary Physician

Physician's Name: _____

Address: _____ Telephone: (____)_____

Camper's Name: _____ Primary Language: _____

Address: _____ Telephone: (____)_____

Weight: _____ Kgs Height _____ Blood Pressure: _____ / _____

Date of Last Examination: _____

PHYSICAL EXAMINATION

Normal/Abnormal Abnormalities Explained

General
..... Head
..... Neck
..... Eyes
..... Ears
..... Nose
..... Mouth
..... Throat
..... Chest
.....
.....

Heart

 Abdomen
 Skin

 Lymphatic

 Neurological

 Orthopedic

 Psychological

Additional Information: _____

Assessment:

Recommendations:

Physician's Signature Date

General Medical Information: (to be completed by parent)

| Other medical problems (please check) | No | Yes | Explanation |
|---------------------------------------|-----|-----|-------------|
| Heart disease..... | ... | | |
| | | | Kidney |
| disease..... | ... | | |
| | | | |
| Epilepsy..... | ... | | |
| | | | |
| Seizures..... | ... | | |
| | | | |
| Diabetes..... | ... | | |
| | | | |
| Asthma..... | ... | | |
| | | | |

Hayfever..... ...

Bed Wetting..... ...

Behavioral /Learning Problems

Drug Allergies..... ...

Other Allergies..... ...

Assistive devices (glasses, earplugs)..... ...

Other..... ...

List surgical procedures and/or major complications:
.....
.....

Dietary restrictions:
.....
.....

Religions preference (optional)

| Medications: | Name | Dosage | Frequency |
|--------------|-------|--------|-----------|
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

Hospitalizations in past year: no yes

If yes, explain _____

Parent signature: _____

Immunization Information: (to be completed by parent)

CAMPERS CANNOT BE ACCEPTED IF THIS SECTION IS INCOMPLETE

Dates of immunizations:

Polio vaccine _____ Measles vaccine _____
Rubella vaccine _____ Mumps vaccine _____
HIB vaccine _____ Diphtheria-tetanus booster
_____ Hepatitis A vaccine _____ Hepatitis B
vaccine _____ TB skin test and date _____
(neg _____ pos _____) Tetanus _____ Other _____

Bleeding disorder Information: vonWillebrand disease

(to be completed by parent)

Type of von Willebrand Disease: 1 2A 2B 2M 2N 3 other _____

Major sites of Bleeding:

Nose: _____

Joints: _____

Muscle: _____

Soft Tissue (bruising): _____

Heavy periods: _____

Other: _____

Von Willebrand Treatment Protocol:

Bleeding Disorder Information: Hemophilia

(to be completed by parent)

Type of Bleeding Disorder: FVIII FIX
Level _____ Inhibitor: no yes Date of inhibitor diagnosis: _____

Date of last inhibitor test: _____

Current Inhibitor titer (Bethesda Units): _____

Major sites of Hemorrhages:

Joints: _____ Muscle: _____
Soft Tissue (bruising): _____ Other: _____

Bleeding Disorder Treatment Protocol:

Do you infuse at home? Does your child infuse himself/herself Is your child on prophylaxis? Does your child have a port or central line? Is your child on immune tolerance?
yes yes no no no no no
yes yes
yes

Infusion product: **factor concentrate** Type **DDAVP**
(Brand Name):

Type (Brand Name): _____

On Demand therapy (only when bleeds occur):

Units/treatment: Major bleeds _____ units / Minor bleeds _____ units

How many times do you/your child infuse per month? _____

How many infusions are usually needed per bleed?

Prophylaxis therapy or immune tolerance (circle one):

Day/units Day/units Has your child ever had a reaction to factor?

no yes If yes specify _____ Do you pre-treat with any medication before an infusion? no yes
If yes specify _____

Does your child have hepatitis B? yes no Does your child have hepatitis C? yes no Blood type: _____ (if known)

Parent Signature: