



17000 Elizabeth Lake Rd.  
 PO Box 455  
 Lake Hughes, CA 93532  
 Tel 661-724-1768  
 Fax 661-724-1566

Hello parents and friends!

Camp sessions at The Painted Turtle are just around the corner and we're very excited to share yet another remarkable summer with all our campers.

So that we may provide the best care possible, we want to know as much as we can about your child before he/she arrives at camp. This means asking you to completely fill out the enclosed forms to help us thoroughly understand your child's specific medical and social needs.

Although we wish we could take every child who applies to camp, we may not have room for everyone to attend. We will let you know in May if your child is accepted for camp. We're looking forward to a magical summer!

Gina M. Jansheski, MD, FAAP  
 Medical Director

April Uyehara  
 Camp Director

**SKELETAL DYSPLASIA/MPS SESSION APPLICATION CHECKLIST**  
**Camp Session June 15-20, 2012 for campers age 7-16**

Please note, the camper must fulfill the following criteria:

- Minimum developmental age of 5 years
- Ability to communicate needs independently
- Ability to function and participate in a group
- Can be without a family member for the duration of the camp session

**• For the safety of all our campers, we require that all your child's immunizations are up to date. Please review the attached Immunization Requirements and arrange to have any necessary vaccines given and completed prior to camp session.**

• Please schedule your doctor's appointment well in advance (we suggest on or before March 1<sup>st</sup>) to ensure time for your specialist to complete the medical forms.

• When all forms are complete, please return to:  
 Please be advised that it is your responsibility to follow up with The Painted Turtle to ensure that all application materials are received and complete.

Rosalyn Skelton                      or by fax  
 The Painted Turtle                      661-724-1566  
 PO Box 455  
 Lake Hughes, CA 93532

	<b>Form</b>	<b>Description</b>	<b>Filled Out By</b>
<input type="checkbox"/>	Painted Turtle Camper Application	Contact/emergency information/medical information	Parent
<input type="checkbox"/>	Authorization and Release Form	Safety/liability-Signature required	Parent
<input type="checkbox"/>	Copy of Insurance Card	Insurance Information	Parent
<input type="checkbox"/>	Copy of Immunization Record	See Immunization Requirements	Parent
<input type="checkbox"/>	Physician's Medical Form and Activities clearance	Physical exam by specialist (please schedule appointment as soon as possible to allow for time to complete the form)	Specialist
<input type="checkbox"/>	Severe Allergy Action Plan Form	For campers with severe allergies requiring Epi-pens	Allergist
<input type="checkbox"/>	Teacher Questionnaire	Child's profile	Teacher

Please include a photograph of the camper

**The entire completed application must be returned by April 1, 2012, to be considered for a camp session.**

If you have any questions regarding the application, please contact Rosalyn Skelton at The Painted Turtle, 661-724-1768 ext 203 or rosalyns@thepaintedturtle.org.

# The Painted Turtle 2012 Camper Application

CHECK ONE SESSION

- Skeletal Dysplasia/MPS: June 15-20     Kidney Disease and Transplant: June 24-29     Special Diagnoses; July 3-7  
 Rheumatic Disease:s: July 11-16     Hemophilia/vWF & Thalassemia: July 30-August 4  
 Liver Transplant, PIDD, and TPN: August 8-12

**TO BE COMPLETED BY PARENT OR GUARDIAN (Please print legibly.)**

## Camper information

First Name  Last Name  Nickname

Age at Camp  Date of Birth   Male  Female School Grade next year ('12-'13)

Camper's Primary Language  English  Spanish  Other  Does camper speak English?

Camper's T-shirt Size   Youth  Adult Does camper use Sign language?

## Parent/Legal Guardian ( If you provide us with an e-mail address then this will be our primary method of communication)

Full Name  Relationship to Camper  E-mail

Home Phone  Work Phone  Cell Phone

Address  City  State  Zip Code

Full Name  Relationship to Camper  E-mail

Home Phone  Work Phone  Cell Phone

Address  City  State  Zip Code

Same as above    If you will not be at home/work while your child is at camp, what number can we use to contact you?

## Custody

With whom does the camper primarily reside? *check all that apply.*

Mother  Father  Stepmother  Stepfather  Brother  Sister  other

If parents are divorced, who has legal custody?

Significant custody notes:

Is your child involved with DCFS (Department of Child and Family Services)?  Yes  No If yes, is it an open case?  Yes  No

Name of person completing application  Relationship to camper

## Emergency Contacts

Please list **TWO** adults (**other than the child's parents or guardian**) who, in case of an emergency, The Painted Turtle may contact and/or turn your child over to if you are not available. Please ensure contacts are aware of camp name and session dates.

Full Name  Relationship to Camper

Home Phone  Work Phone  Cell Phone

Full Name  Relationship to Camper

Home Phone  Work Phone  Cell Phone

Camper Name

**Medical Provider Contact Information This section MUST be completed in full.**

Pediatrician	<input type="text"/>	Office Phone	<input type="text"/>
Specialist	<input type="text"/>	Hospital	<input type="text"/>
Fax Number	<input type="text"/>	Office Phone	<input type="text"/>
Nurse/Coordinator	<input type="text"/>	Office Phone	<input type="text"/>
Social Worker	<input type="text"/>	Office Phone	<input type="text"/>
Other (specify)	<input type="text"/>	Office Phone	<input type="text"/>

**Insurance Information: Campers MUST provide proof of medical insurance coverage.**

**Note:** You **MUST include a TWO-sided copy** of your insurance card (and a pharmacy card, if applicable.) If you would like to speak with someone about our insurance policy, please contact the Camper Admissions at 661-724-1768.

**Immunization Record**

You **MUST include** a copy of your child's **current immunization record.** *Please see immunization policy*

**Treatment Record**

	Date of Most Recent	Reason for Most Recent	Number in Past 12 Months
Doctor Visit			
ER Visit			
Hospitalization			
Surgery			

**Medical History**

Diagnosis  Date of Diagnosis or Transplant:

Date of Repeat Transplant (if applicable):

Yes  No Does your child have any surgeries planned before camp? If yes, please explain.

**Other Medical Conditions:** Check any other medical conditions your child has.

- arthritis       hypertension       constipation       kidney or Urinary Tract Infections       hearing loss
- bleeding disorder       palpitations       stool incontinence       urinary incontinence       vision loss
- diabetes       fainting       migraine headaches       chronic sinusitis       other condition
- immunodeficiency       anal fissure       rash/eczema       PE/ear tubes
- seizures      Date of last:       Type:       Duration:
- asthma severity:       mild       moderate       severe      Is an inhaler used?       Yes       No

Please provide any important details regarding your child's primary medical condition and any other conditions checked above.

Camper Name

**Current Medication Regimen:** (Oral Medications, Vitamins, Supplements: List ALL of the oral medications, vitamins, supplements your child is currently taking on a regular basis.) **\*Please bring these medications.**

Drug Name	Strength/ concentration	Breakfast (8:30 am)	Lunch (12:30 pm)	Dinner (6:00 pm)	Bedtime (between 8:30-9:30pm)
Example Drug XYZ	1 pill = _____ mg	1 pill	NA	2 pills	NA
Liquid Medication	1 ml = _____ mg	5ml	5 ml	10 ml	NA

**IV Medications/Intravenous, Subcutaneous and Intramuscular:** Include ALL, even those not taken daily.

Drug Name, Strength/ Concentration	Route (IV, IM, SQ)	Dose	Frequency	Rate\Hour	Type of pump

**Over the counter:** List any over the counter medications that are taken as needed (i.e. for headaches, heartburn, menstrual cycle) specifying the name of the drug, frequency and the corresponding dosage. **\*Please bring these medications.**

Drug Name	Strength	Dose	Frequency

**Anatomy/Devices:**

Please place a check next to any of the following that your child has.

 Check if NONE Hearing Aids  PE Tubes VP Shunt Neurosurgeon's Name:  Phone:  Glasses/Contacts Oxygen Rate:  L/hr by:  cannula  mask Hours used:  Oxygen sat monitor CPAP or  BiPAP Brand:  Name of Device  Tracheostomy Type/Size:  Suction every:  hrs Suction catheter size:  Ventilator Type:  Hours of use:  Settings:  NG-tube or  GJ Tube or  G-tube**Formula Type:**  **(Please send enough for the entire session, plus 1 day)**Schedule of feeds:  Bolus  ml Times:  J-Pouch  Continuous Rate  /hr Start time:  End time:  ACE/Malone Irrigation Frequency:  Amount:  ml With:  solution.**Level of assistance required**  Independent  Needs Supervision  Requires irrigation by Staff Ostomy  Velcro closure  Closed end  Clipped end Insulin Pump Other:  Central line Type:  (i.e. PICC, Portacath) Needs urinary catheterization Cath Size:  Every:  hours Times:   
Size of catheterization  Mitrofanoff  Urethra**Level of assistance required**  Independent  Needs Supervision  Requires Cathing by Staff Peritoneal Dialysis Catheter  Hemodialysis Catheter Yes  No **Does your camper need any care at night time? (i.e. change G tube feed, catheterization, turning in bed, etc.?)****Daily Activity Participation**

Please indicate below if your child requires help or assistance with any of the following.

	Needs reminder	Needs Moderate assistance	Requires Total Care
Daily Care (i.e. dressing, brushing teeth)			
Bathing / Showering			
Meals			
Toileting / Bathroom			

Can your child walk 1/4-1/2 mile unassisted several times a day?  Yes  No

Does she/he require any of the following ?

 Wheelchair  Leg Braces  Splints/Orthotics  Crutches  Other Comments What is your child's swimming level?  doesn't know how  beginner  intermediate  advanced**All activities are supervised** and include but are not limited to : 1. archery, 2. arts & crafts, 3. baking/cooking, 4. boating, 5. creative arts (writing & photo), 6. discovery (science & nature), 7. fishing, 8. gardening, 9. horseback riding, 10. outdoor camping and cooking, 11. performing arts, 12. ropes course, 13. sports & recreation, 14. swimming, 15. woodworking. \* **See Authorization and Release for consent/restrictions\***

**Behavioral/Emotional Conditions:** Check any behavioral or emotional conditions that your child has been diagnosed with.

- Anxiety     Depression     ADD/ADHD     Aspergers     PDD/autism     Other   
 Bipolar Disorder     OCD/OC Behaviors     Tics/Tourette's     PTSD

- Yes     No    Has your child been **prescribed** any medication for the above-checked items?  
 Yes     No    Is your child currently taking those medications as prescribed?

If not, why?

- Yes     No    Does your child have a history of any self-harming behaviors, including cutting?

If yes, please explain.

**Camp/Sleep-away Experience:** Please tell us your child's sleep-away experience.

- Little to no sleep-away experience                       Has been away from home without parents for 5 days  
 Has attended another sleep-away camp                       Has attended The Painted Turtle

- Yes     No    Is your child planning to attend another camp other than The Painted Turtle this summer?    If yes, name of camp:   
Is it a sleep-away camp?     Yes     No

- Yes     No    Were there any special medical accommodations made so that your child could attend camp?

**Attitude about camp:** How does your child feel about going to camp? ( hopes, fears, concerns, etc.)

Please give us a brief description of your child's personality: (check all that apply)

- Outgoing                       Shy                       Leader                       Mature for age                       Assertive  
 Playful                       Slow to warm up                       Follower                       Aggressive                       Easily Frustrated  
 Makes friends easily                       Sensitive                       Competitive                       Especially active  
 Helpful                       Patient                       Cooperative  
 Participates well with others                       Other

**Bedtime:** Please check any sleep concerns your camper may have.

- bedwetting                       fear of dark                       sleepwalking                       nightmares                       night terrors   
 difficulty waking                       snoring                       talks in sleep                       difficulty falling a sleep                       other

Comments: Are there any bedtime routines that help your child at night?

**Communication:** Campers must be able to communicate their needs while at camp. Does your child have any special communication needs (sign language, spelling boards, etc.)?

**Does your child receive additional education support?** (examples include an IEP, Resource, specialized classes)

- Yes                       No

If yes, please explain.

Camper Name

**Camper Profile (continued)**

**At what age does your child function?**

Does your child interact best with children their own age, older or younger?

**1:1 Support:** Are there circumstances where your child requires additional 1:1 support (transitions, meals, getting ready for the day, large groups, etc.)

**Camper Conduct**

Yes  No Has your child been convicted of a crime, been on probation, or in rehabilitation for any reason? If yes, please explain.

Yes  No Has your child ever tried to run away from home or a group event or trip? If yes, please explain.

Yes  No Has your child ever been in a physical fight or suspended from school? If yes, please explain.

**Attitude about medical condition:** Please check which, if any, medical condition-related issues are hardest for your child to manage/cope with.

Peers/relationships  Body image  Adherence/compliance  Other

Comments

At times, all children can feel frustrated or angry. When your child is angry, how does he/she handle his/her anger? Any suggestions for helping your child in such situations?

Yes  No Does your child have any unusual behaviors or fears?

If yes, please explain.

Have there been any changes in your child's life, family, or living arrangements, or significant past history? Check all that apply.

Death  Divorce  Remarriage of Parent  Foster Care  Moving

Change schools  Other

**Is there any additional information you would like to share about your child?**

Camper Name

Session

### Allergies and Special Dietary Considerations/Restrictions Form

**Allergies:**  Check if NONE

List all Allergies	List Allergy	Describe Reaction	If Epi-pen is required, please complete <b>Severe Allergy Action Plan Form</b>
<b>Medication</b> (Example: Penicillin)			<input type="checkbox"/> Requires Epi-pen
1.			<input type="checkbox"/> Requires Epi-pen
2.			<input type="checkbox"/> Requires Epi-pen
3.			<input type="checkbox"/> Requires Epi-pen
<b>Other</b> (Examples: LATEX, Horses, Bee Stings)			<input type="checkbox"/> Requires Epi-pen
1.			<input type="checkbox"/> Requires Epi-pen
2.			<input type="checkbox"/> Requires Epi-pen
3.			<input type="checkbox"/> Requires Epi-pen
<b>Food</b> (Example: Peanuts, Shellfish)- <b>ALLERGIES ONLY</b>			<input type="checkbox"/> Requires Epi-pen
1.			<input type="checkbox"/> Requires Epi-pen
2.			<input type="checkbox"/> Requires Epi-pen
3.			<input type="checkbox"/> Requires Epi-pen

Yes  No Has the above-named individual seen an allergist for these allergies? If yes, Name:  Phone:

**NOTE: If your child requires an epi pen, please bring to camp!**

**NOTE: If your child has severe allergies, please have their allergist complete the "Severe Allergy Action Plan" form.**

- Check if milk allergy, and please indicate type of reaction
- Yes  No Does milk protein cause anaphylaxis?
- Yes  No Can your child have trace amounts of milk? (i.e. in cookies)
- Yes  No Is this lactose intolerance?

What dairy products can your child have? (i.e. cheese, ice cream)

Yes  No Does your child drink Supplemental formula (such as Pedialyte, Ensure)?

How Often  Amount

Yes  No Does your child require anything besides water to take medication?

**Dietary Considerations/Restrictions**  Check if NONE

The Painted Turtle tries to accommodate special dietary needs of campers. Certain specialized needs will require parental support to ensure that dietary needs can be adequately met. Also, The Painted Turtle is a peanut, and tree nut free facility.

- No Dietary Restrictions  Dietary Restrictions: (Not Allergies)
- 1)  3)  5)
- 2)  4)  6)

Yes  No **Can your child self-manage these dietary restrictions?**

Yes  No Does your child have a specific medically-prescribed diet(i.e., pureed foods only, thickened liquids, etc.?)

If yes, please explain:

Does your child have any physical disabilities and/or conditions that make eating and/or drinking difficult (i.e. swallowing difficulties, poor muscle tone, spasticity, etc.)? If so, please explain below, including accommodations that need to be made while your child is at camp.

Are there any other special considerations or insights we should know about your child and his or her dietary restrictions/concerns? If so, please explain below:

# Severe Allergy Action Plan

For camp participants with a severe allergy, requiring use of an Epi-pen

**This form must be filled out in its entirety by allergist**

Place Photo Here

Name  Date of Birth

Camp Session

Severe allergy to:  **Weight (kgs)**

Extremely reactive to the following foods:

**Asthma:**  Yes (higher risk for a severe reaction)  No

Has this patient had a sudden and severe episode of anaphylaxis?  Yes  No

Please choose an action plan:

- Give epinephrine immediately at the **first sign of any** symptom.
- Give epinephrine **immediately after a known exposure** to an allergen which has caused a severe reaction in the past,(i.e. food, bee sting) **even if no symptoms are noted.**
- Give epinephrine **with signs or symptoms of anaphylaxis.**

Other action plan:

Special instructions or precautions:

## Medications/Doses

Epinephrine (brand and dose):

Antihistamine (brand and dose):

Other (i.e. bronchodilator, if asthmatic):

Parent/Guardian Signature

Date

Physician (Allergist) Signature

Date

Physician Name

Specialty

Physician Phone

On Call Phone

Camper Name

Date of Birth

## Confidential Campership Information

*The Painted Turtle is made possible through generous donations and grants from public and private organizations. Without these generous gifts, the cost for each camper to attend a week at camp would be approximately \$2500. Please complete the following information, which helps our prospective donors evaluate our programs. This information is for demographic purposes only, and will remain anonymous and confidential. This information is for demographic purposes only, and will remain anonymous and confidential.*

Camper's age

Zip Code

County of Residence

### Ethnicity:

African-American

American Indian

Asian/Pacific Islander

Latino

White

Other

What is the **TOTAL** number of persons residing in the home?

### Annual Family Income

Please check the amount closest to your family income:

 \$0 - \$5,000 \$6000 - \$8,000 \$8,000 - \$10,000 \$10,000 - \$12,000 \$12,000 - \$15,000 \$15,000 - \$20,000 \$20,000 - \$26,000 \$26,000 - \$31,000 \$31,000 - \$36,000 \$36,000 - \$42,000 \$42,000 - \$47,000 \$47,000 - \$53,000 \$53,000 - \$55,000 \$55,000 - \$60,000 \$60,000 - \$65,000 over \$65,000

### California County and Governmental assistance

If you and your child(ren) receive assistance, please indicate below:

 TANF SSI

How did you hear about The Painted Turtle?

 Painted Turtle Outpost Partner Organization Clinic visit from Painted Turtle staff Internet Word of mouth Medical Provider Former camper Other

## The Painted Turtle

### Authorization and Release Form 2012

Name of child who will be a camper at The Painted Turtle Camp:  
(hereinafter referred to as the "Applicant:)

**Note:** Please read the following information carefully. Every item on this page must be understood before signing. If there are any questions, please call The Painted Turtle at (661)724-1550 for clarification.

The Painted Turtle Camp is located at 17000 Elizabeth Lake Road, City of Lake Hughes, State of California (hereinafter referred to as the "Camp").

I certify that I am the parent or legal guardian of the above named Applicant.

I understand that Applicant will be participating in many physical activities at The Painted Turtle Camp. All Camp activities are supervised.

Equestrian activities are conducted in controlled riding arena. Our equestrian staff members are trained professionals, and the safety of the child is always paramount. Supervised, led trail rides may also be offered to children with parental/medical approval.

The Camp also provides a high and low ropes program that offers an adventurous opportunity and is supervised by professionally trained program staff. All participants wear the safety equipment provided, including helmets and harnesses.

The Camp's swimming program is supervised by professionally trained and certified life guard staff. The chlorinated and heated swimming pool has wheelchair accessible water entry and is universally accessible.

The Camp is in development of an organic gardening program that will involve campers digging in the soil and planting/harvesting flowers, fruit and vegetables at camp. Garden gloves are used for all gardening activities and edibles are washed thoroughly before cooking or consumption.

I authorize the Camp medical staff to provide the Applicant with medical care which is deemed necessary by the Camp medical staff.

I authorize the Camp medical staff to consent to any emergency medical care or treatment, including the dispensing of medicine, examinations, immunizations, x-rays, tests, dental care, anesthetics, medical or surgical diagnosis or treatments, and hospital care, to be rendered to the Applicant as deemed necessary by the Camp medical staff.

I also give consent for any transportation deemed necessary or appropriate, at the discretion of the Camp, in connection with the medical treatment of the Applicant.

I assume financial responsibility for any and all medical and other expenses incurred for or on behalf of the Applicant while at the Camp or offsite.

**DIABETES CAMPERS ONLY:** I authorize the Camp medical staff to provide the Applicant with medical care, which is deemed necessary by the Camp medical staff, including but not limited to the adjustments of insulin and diet as needed based on the decision of medical staff. Applicant may also participate in medical and dietary education and education about insulin administration and adjustment.

I authorize Camp medical staff to release Applicant's medical records to Camp medical and non-medical staff and to third parties, for the purpose of Applicant's medical treatment, the non-medical care of Applicant, referral, billing, or insurance purposes, as deemed necessary by Camp medical staff.

I authorize individuals(s) listed as "emergency contacts" to pick up my child from camp or its bus stop and to authorize medical care.

I authorize Camp staff to provide transportation to the Applicant, as needed, while the Applicant attends the Camp. I release the Camp from all claims, damages and liabilities that may result, directly or indirectly, from any injury that Applicant may suffer during such transportation.

## Authorization and Release Form 2012

I authorize the Camp Director to return the Applicant to his/her home for any serious violation of the Camp rules. I agree that the Camp Director shall be the sole judge of what constitutes a serious violation.

I understand that, in order for Applicant to attend the Camp, I must give up any rights to hold the Camp liable for any injury or damage, which the Applicant may suffer while attending the Camp or participating in the activities offered at the camp.

I voluntarily release the Camp, its officers, agents, and employees from any and all liability resulting from or arising out of the Applicant attending the Camp or participating in the activities offered by the camp.

I understand and agree that this Release will have the effect of releasing, discharging, waiving and forever relinquishing any and all actions or causes of action that I may have or have had, whether past, present or future, whether known, or unknown, and whether anticipated or unanticipated by me, arising out of the Applicant attending the Camp and/or participating in the activities offered by the Camp. This Release constitutes a complete release, discharge and waiver of any and all actions or cause of action against the Camp, it's officers, agents, or employees.

I understand and agree that this Release will be binding on me, my spouse, the Applicant, my heirs, my personal representatives, my assigns, my children and any guardian ad litem for said children. I understand and agree that by signing this Release, I am agreeing to indemnify and hold the Camp, its officers, agents and employees harmless from any and all liability or cost, including attorneys fees associated with or arising from the Applicant attending the Camp and/or participating in the activities offered by the Camp.

I have read the above information carefully, and I have fully understood each item. I understand that if I have any question regarding anything contained in this Release, I may call The Painted Turtle at (661)724-1550 for an explanation.

I understand that as a condition of Applicant attending The Painted Turtle, the camp may use Applicant's name, photographs, other reproduction(s) and likenesses in connection with activities and publication's of the Camp. The Painted Turtle respects the privacy of its campers and their families and does not allow unauthorized visitors to photograph its campers.

I am authorizing my child to participate in all activities at camp. If there are any exceptions, please list below.

**Activity Exceptions:**

This Release has been executed as of  2012

Print Name

Signature

Relationship to Applicant

### The Painted Turtle

**17000 Elizabeth Lake Rd., PO Box 455 Lake Hughes, CA 93532**

**Phone: 661-724-1768 / Fax: 661-724-1566**

**This form must be completed by the camper's parent or legal guardian.**

Name of Camper  Session

**For the safety of your child, please indicate how your child will be traveling to/from camp and list the names of adults who are authorized to pick up and drop off your child.**

Detailed transportation information including bus locations and times will be sent in your camper's Welcome Packet upon acceptance to camp.

Please check how your child will be getting to camp:

- My child will be dropped off at camp
- My child will be arriving on the bus
- My child will be flying to camp
  - My child will be flying as an unaccompanied minor

Please check how your child will be getting home from camp:

- My child will be picked up from camp
- My child will be departing on the bus
- My child will be flying home from camp
  - My child will be flying as an unaccompanied minor

My child will be brought to camp/bus location by:(name)

Relationship to Camper:  Phone Number:

My child will be picked up by:(name)

Relationship to Camper:  Phone Number:

Please list names of any additional adults who are authorized to pick up and drop off your child:

Name	<input type="text"/>	Relationship to Camper:	<input type="text"/>	Phone Number:	<input type="text"/>
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Name	<input type="text"/>	Relationship to Camper:	<input type="text"/>	Phone Number:	<input type="text"/>
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Name	<input type="text"/>	Relationship to Camper:	<input type="text"/>	Phone Number:	<input type="text"/>
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**\*Your child will not be released to anyone other than the person(s) listed on this form. Identification of parents/guardians/ authorized adult will be checked at camper drop off and pick up. Please have an official form of picture identification when dropping off and picking up your child.\***

**If there are any changes regarding your camper's arrival or departure, or the authorized adults you must contact Rosalyn Skelton at 661-724-1768 ext 203 or [rosalyns@thepaintedturtle.org](mailto:rosalyns@thepaintedturtle.org).**

**If we are not notified of any changes, we will follow this sheet as scheduled.**

By signing this form, I acknowledge that I am a parent/legal guardian of the camper and that the adults listed have authorization to transport my child to/from camp.

Signature of Parent/ Legal Guardian  Relationship to Camper:  Date:

Print Name:  Telephone Number:

# Teacher Questionnaire

Child's Name:  School:

Teacher Name:  Phone number:

E-mail Address:

*This child has applied to attend The Painted Turtle, a medical specialty summer camp. Your supplying the following information will help us provide the most positive experience possible for our campers. Teachers often have been insight into how kids interact with their peers, accept direction/discipline, express their frustrations, learn and understand, and most importantly what it is they enjoy doing. Thanks for taking the time to help us! Please return this form to the parent when complete.*

1. Please give us a brief description of your students's personality: (check all that apply)

- |  |  |                                      |  |  |
|--|--|--------------------------------------|--|--|
| <input type="checkbox"/> Outgoing                      | <input type="checkbox"/> Shy             | <input type="checkbox"/> Leader      | <input type="checkbox"/> Mature for age    | <input type="checkbox"/> Assertive         |
| <input type="checkbox"/> Playful                       | <input type="checkbox"/> Slow to warm up | <input type="checkbox"/> Follower    | <input type="checkbox"/> Aggressive        |  |
| <input type="checkbox"/> Makes friends easily          | <input type="checkbox"/> Sensitive       | <input type="checkbox"/> Competitive | <input type="checkbox"/> Especially active | <input type="checkbox"/> Easily Frustrated |
| <input type="checkbox"/> Helpful                       | <input type="checkbox"/> Patient         | <input type="checkbox"/> Cooperative |  |  |
| <input type="checkbox"/> Participates well with others | <input type="checkbox"/> Other           | <input type="text"/>                 |  |  |

2. In what area of the child's life does she/he feel the greatest sense of success?

3. What kinds of social challenges does the child encounter while in school?

What have you found to be the best way to help him/her resolve these challenges?

4. Has the child ever been suspended, or expelled from school for any reason?

- Yes If yes, please give the age of the child at the
- No time of the incident and an incident description.

5. What grade is this child currently in?  Does she/he work at that grade level?  Yes  No

Does she/he have a learning disability or developmental delay?  Yes  No

If yes, please explain.

6. Describe how this student is perceived by peers:

7. Is there any information that has not been covered that you feel would be helpful to us? (i.e., recent changes in the child's world, life stressors, difficulty in school, difficulty with peers, etc.)

Teacher Signature:

Date:

Parents Signature:

Date:

The Painted Turtle  
17000 Elizabeth Lake Rd., PO Box 455  
Lake Hughes, CA 93532  
Tel 661-724-1768 Fax 661-724-1566

# Camper Medical Provider Form - Médico de campista Proveedor Forma

To Be Completed By Child's **Specialist** Provider - Ser Completado Por Proveedor de Asistencia médica (Physician/Nurse Practitioner/Physicians Assistant) Prior to Submission Of This Application **(Each page must be signed by provider)**  
Please Be As Detailed As Possible And Answer All Questions. **If child routinely has lab work, please attach most recent lab results.**

Please note, the camper must fulfill the following criteria:

- Minimum developmental age of 5 years
- Ability to communicate needs independently
- Today's Date
- Ability to function and participate in a group
- Can be without a family member for the duration of the camp session.

Camper Name  Date of Birth

Parent/Guardian Name  Phone Number

Primary Diagnosis  Date of Diagnosis   
With any subclassification

State of Current Condition  Stable  Flare  Medicated Remission  Remission  Other

### RESPIRATORY

- Sleep Apnea
- Oxygen requirement
- Chronic Lung Disease
- Asthma

### NEUROLOGIC

- Migraine
- Spasticity
- Severe Visual problems
- Developmental delay
- Seizures

### INFECTIOUS DISEASE

- Recurrent GAS
- Recurrent skin infection
- Hepatitis B or C
- HIV
- TB
- Asplenia

### MUSCULOSKELETAL

- Spinal fusion
- Fracture risk
- OTHER**
- IV or Sub Q meds
- Pregnancy

### GI

- Constipation
- TPN dependent
- Eating disorder

### HEMATOLOGIC

- Bleeding risk
- HAT/PVT
- BMT

### IMMUNOLOGIC

- PTLD
- Acute or chronic rejection
- Autoimmune hepatitis

### GENITOURINARY

- Enuresis
- Urinary incontinence
- Stool incontinence

### CARDIAC

- Hypertension
- Heart Disease

### ENDOCRINE

- Diabetes Type 1
- Diabetes Type 2
- Requires Insulin
- Growth failure

Type  Duration  Date of last Seizure

Explanation

### **Significant past medical history/other medical conditions:**

Yes  No Is the child developmentally appropriate for his/her age? If no, at what (approximate) age does child function?

List any communication problems, pertinent psychosocial information, or behavioral problems that would affect the child's participation in a group:

Major Surgeries & Dates (e.g. transplants)

Yes  No Has the child been hospitalized in the last 6 months? If yes, diagnosis.

Please include a copy of the child's discharge summary and most recent clinic note.

### **Infection Control-These questions MUST be answered:**

Yes  No **Live vaccines deferred?** If yes, explain why:

Yes  No **Has the child ever had chicken pox or shingles?**  Unknown Year of infection

Are you aware of any positive history for:

Yes  No **HA-MRSA** If yes, date cleared

Yes  No **VRE** If yes, date cleared

Yes  No Has the child had any infections in the past 6 months? If yes, diagnosis.

Physician's Signature  Date

**We cannot accept these campers unless infection has been cleared**

Camper Name

Date of Birth

**Devices**

Yes  No Central venous line/  
Port-a-cath Type  Location   
*If yes, please complete CV Catheter Form.*

Yes  No Tracheostomy Type/Size  Date of last change

- Apnea/O<sub>2</sub> Monitor
  - CPAP/BiPAP
  - Ventilator
  - Oxygen
  - VP Shunt
  - Insulin Pump
  - G-tube
  - NG-tube
  - Bile Tube
  - Ostomy
  - J-Pouch
  - PE Tubes
  - Hearing Aids
  - Glasses/Contacts
  - Malone / ACE
  - Urinary Diversion, (Mitrofanoff)
- If yes, name of Neurosurgeon:  Phone Number:

**Bladder/Bowel Treatment Program:**  Yes  No Prescribed bladder/bowel management program?

Needs urinary catheterization Cath Size:  Every:  hours Times:   
Size of catheterization  Mitrofanoff  Urethra Needs to cath at night  Yes  No

**Level of assistance required**  Independent  Needs Supervision  Requires Cathing by Staff

Malone/ ACE ACE irrigation  times a day with  cc Normal Saline

**Level of assistance required**  Independent  Needs Supervision  Requires Irrigation by Staff

Any Additional Instructions:

<b>List all Allergies</b> <input type="checkbox"/> None	List Allergy	Describe Reaction	If Epi-pen is required, please complete <b>Severe Allergy Action Plan Form</b>
<b>Medication</b> (Example: <b>Penicillin</b> )			<input type="checkbox"/> Requires Epi-pen
1.			<input type="checkbox"/> Requires Epi-pen
2.			<input type="checkbox"/> Requires Epi-pen
3.			<input type="checkbox"/> Requires Epi-pen
<b>Other</b> (Examples: LATEX, Horses, Bee Stings)			<input type="checkbox"/> Requires Epi-pen
1.			<input type="checkbox"/> Requires Epi-pen
2.			<input type="checkbox"/> Requires Epi-pen
3.			<input type="checkbox"/> Requires Epi-pen
<b>Food</b> (Example: Peanuts, Shellfish)- <b>ALLERGIES ONLY</b>			<input type="checkbox"/> Requires Epi-pen
1.			<input type="checkbox"/> Requires Epi-pen
2.			<input type="checkbox"/> Requires Epi-pen
3.			<input type="checkbox"/> Requires Epi-pen

**List Current Medications or attach typed medication sheet**

**Does the child have:**

- Yes  No Food Restrictions/Special Diet:  If yes, please explain
- Yes  No Special Mobility Needs (e.g. wheelchair, walker, leg braces, etc.):  If yes, please explain
- Yes  No Special Infection Control Precaution :  If yes, please explain

Physician's Signature

Date

**Physical Exam: These questions must be answered**

Height (inch/cm)  Weight  BP  HR   
**Please check if normal or give details of abnormalities below.**

**Head:**  Normal  VP Shunt  Other

**Eyes:**  Normal  Nystagmus  Strabismus  Amblyopia  Decreased Vision  Other

**Ears:**  Normal  PE Tubes  Abnormal Hearing  Cochlear Implant  Other

**Nose/Mouth:**  Normal  Significant congestion/Rhinorrhea  Oral Sores  Other

**Teeth:**  Normal  Orthodontia  Caries  Gum Disease  Other

**Neck:**  Normal  Trach  Atlantoaxial Instability  Abnormal Nodes  Other

**Chest:**  Normal  Chest Wall Abnormality  Wheezing  Other

**Heart:**  Normal  Murmur  Arrythmia  Other

**Abdomen:**  Normal  Urinary Diversion  Ostomy  G-tube  
 Palpable Liver/Spleen  cm below costal margin  Other

**Genitalia & Rectum:**  Normal  Perianal Fissure/Tag  Hemorrhoids  Other

**Neurological:**  Normal  Paraplegia  Spasticity  Other

**Musculo-skeletal:**  Normal  Amputation(s)  Weakness  Contractures  Other

**Skin:**  Normal  Decubiti  Petechiae  Excessive Bruising  Burns  Eczema  Psoriasis  Scarring  
 Other

**Back:**  Normal  Spina Bifida  Scoliosis  Kyphosis  Other

**Please explain abnormalities noted above:**

**Physician/Medical Provider's Statement:** I have examined  and find him/her physically able to attend camp.

Comments

Signature  Print Name  Date

*If completed by a nurse:* As the RN working with   MD  NP  PA

I have reviewed the camper's medical information and camp application with the child's physician/NP/PA. He/she has given approval of all the information and recommendations reported on these camp medical forms and has given me permission to sign this form on his/her behalf.

Clinic Name  Hospital Affiliation  Phone Number   
 Fax Number  Emergency/On Call Phone  E-mail

# PHYSICIAN CLEARANCE FOR ACTIVITIES

**NOTE: This form must be signed by Camper's physician. Please fax to: 661-724-1566.**

Camper Name:

Session:

## Is Camper Cleared for this activity?

Please check Yes or No below:

Yes  No **Horseback Riding (Horses maintain a walking pace at all times.)**

- Riding takes place on ½ mile trail or in the riding arena with side walkers at both locations.
- North American Riding for the Handicapped Association (NARHA) guidelines are strictly followed.
- Infection control measures are in place to protect campers with compromised immune systems.
- BLS certified medical personnel are present at all sessions.
- Campers with the following will be restricted from riding activities (but may participate in horse painting and grooming):
  - Rods after spinal fusion
  - Taking anticoagulant medications
  - Significant thrombocytopenia
  - Seizure within the past 6 months
  - Poor head control
- Camper weight restrictions may apply (generally if >200 lbs).

Yes  No **Swimming**

- All swimming activities take place in a heated, chlorinated pool.
- There is adult and lifeguard supervision of campers in the pool area at all times.
- Swimming program protocols restrict campers with stool incontinence for the safety of all campers.
- Central line care as per separate form (see Central Venous Catheter Form)

Yes  No **High Ropes Course**

- Course is run only with trained professionals, with BLS certified personnel present at all sessions.
- All campers are required to wear helmet and waist harness. Chest harness is used, in addition, if camper has low truncal tone. Campers in wheelchairs are encouraged to participate!
- Campers with the following will be restricted from Ropes Course:
  - Cervical spine instability
  - Taking anticoagulant medications
  - Significant thrombocytopenia
- Restrictions may apply for campers with tracheostomy or seizure disorder.

Yes  No **Organic Gardening**

- No digging activities for campers with compromised immune systems.
- No pesticides are used

**Special care recommendations:**

**For any questions or special considerations, please call Dr. Gina Jansheski at 661-724-1768.**

Physician Signature:

Printed Name:

Phone Number:

Camper Name:

DOB

### Central Venous Catheter Form

Complete only if child has a central line

TO BE COMPLETED BY HEALTH CARE PROVIDER (PHYSICIAN /NURSE)

**Instructions for Catheter Care**  
**Fill out this section ONLY if this child has a central line (i.e. Hickman, Broviac, Portacath, PICC)**

Type of Catheter (Single /Double Lumen; Hickman, Boviac, Groshong, PICC, Portacath)  Date it was inserted

Specific instructions for Catheter care:

How often is it flushed with Heparin?  Amount & Strength of Heparin?

How often is dressing changed?  When is cap changed? (Days of week)

**Special Instructions:**

**All necessary supplies (dressing kits, heparin, syringes, access needles, EMLA, etc.) must be sent to Camp with each child. Children will need 7 dressing kits (or equivalent supplies) if they plan on swimming every day.**

### CENTRAL LINE CONSENT - Unless otherwise specified, all children will be permitted to swim.

This child:  DOES  DOES NOT have permission to go swimming in a chlorine -treated swimming pool.  
(Dressings will be changed immediately following swimming)

Physician's Signature

Date

## THE PAINTED TURTLE 2012 IMMUNIZATION REQUIREMENTS

We are committed to the safety and health of all our campers, camper family members, staff and volunteers.

If you have any questions regarding immunizations, please call to speak with our camp medical staff at **661-724-1768**.

**-For summer camp sessions, follow the guidelines outlined below and *provide an official copy of your child's immunization/vaccination record* with the summer camp application.**

The following vaccines are **REQUIRED**:

REQUIRED Vaccine	Amount Required	Important Notes	Exceptions (If Applicable)
<b>Measles, Mumps, Rubella (MMR)</b>	<b>2 doses</b> MMR vaccine immunization for all campers born on or after 1957 (both must be given ON or AFTER the first birthday)		<p><b>For MMR &amp; Varicella Vaccines:</b></p> <p>Campers who are unable to receive live vaccines, including: transplant recipients, children receiving chemotherapy within the last year, children with a CD4 count less than 15%, children on steroids, remicade, humira, 6mp, and immuran are exempt from receiving the MMR and Varicella vaccines. <b>(Healthcare provider MUST indicate child is exempt on medical form provided).</b></p> <p>Positive titers (blood test indicating immunity) to Varicella, Measles, Mumps, &amp; Rubella are also acceptable</p>
<b>Varicella (Chicken Pox)</b>	<b>2 doses</b> Varivax (Varicella) OR documented history of chicken pox disease or zoster (shingles) infections	<p><b>DO NOT ATTEND CAMP IF:</b></p> <p>-THERE HAS BEEN CONTACT WITH A CHILD OR ADULT WITH <b>Chicken Pox</b> or <b>Shingles</b> IN THE 3 WEEKS PRIOR TO CAMP</p> <p><b>AND/OR</b></p> <p>-A RASH IS ACTIVELY PRESENT (within 2 weeks of vaccination) AT THE SITE OF RECENT VACCINATION</p>	
<b>Tetanus</b>	Initial series of <b>5 DTaP shots</b> <b>**The last Td/Tdap booster must be 9.5 years or less from the beginning of the camp session</b>	Adacel or Boostrix vaccine (which protects against Pertussis-whooping cough) is <i>strongly recommended</i> for children 10 years of age or older who are due for a tetanus booster	
<b>Polio</b>	<b>4 shot series</b> required		
<b>Hepatitis B</b>	<b>3 shot series</b> required	2 dose series of Recombivax HB® is acceptable for children ages 11-15 years, but this must be <b>clearly</b> noted on the vaccine record	

The following vaccines are **STRONGLY RECOMMENDED**:

Recommended Vaccine	Amount Recommended	Important Notes
<b>Hepatitis A</b>	<b>2 shot series</b> for all children over 1 year of age is <i>strongly recommended</i>	
<b>Meningococcal (Menactra) vaccine</b>	For all children over 11 years old as well as for younger children with immunodeficiencies (e.g. functional asplenia, complement deficiency)	