



Camp Holiday Trails

A camp for children with special health needs

400 Holiday Trails Lane · Charlottesville, VA 22903

Phone: (434)977-3781 · Fax: (434)977-8814

ashley@campholidaytrails.org · www.campholidaytrails.org



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Important Information before you begin:



Camp fees for 2010:

Please see the Camper Application for more details



2010 Blazer Program:

ALL campers ages 15-17 must submit the *new* Blazer Program Participant Input Survey ASAP (found on website)



Final Application Deadline: May 31, 2010

Apply early: First come – first served!



Please make an appointment with your child's physician

NOW. All medical forms must be sent in WITH the camper application. (Hint: it may be possible to save on cost or insurance and make this part of a regular checkup appointment vs. a special camp physical appointment)

Application forms also available online: www.campholidaytrails.org



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DEADLINE: 5/31/10

Rec'd: _____

Camp Holiday Trails' mission is to **empower, encourage, and educate** children with chronic illnesses, their families, and healthcare professionals by providing a summer camp and year-round programming aimed at personal growth.

Campers must **have a cognitive level within 1 or 2 years of their actual age**, be able to function in a group, and be able to communicate their needs.

ALL INFORMATION IS CONFIDENTIAL

Please Print



Camper's Name: _____ Male Female

DOB: _____ Age (at time of camp): _____ T-Shirt Size: _____
(Youth or Adult)

2010 CAMP DATES

Please mark ONE circle

BURN CAMP: June 13 – 19

Please visit www.vaburncamp.org for information and application.

Note: Final Session Enrollment may be determined by the health needs of your child

SESSION 1 – YOUNG CAMPER WEEK: June 20 – 25

One week session open to campers from ages 5 – 12 and their siblings from ages 5 – 12
Fee: \$120 (or increase to help other campers)

SESSION 2: June 27 – July 9

Two-week session open to campers ages 7 – 17 | Fee: \$120 (or increase to help other campers)

SESSION 3: July 11 – 23

Two week session open to campers ages 7 – 17 | Fee: \$120 (or increase to help other campers)

SESSION 4: CAMP YOUNGBLOOD with United VA Chapter, National Hemophilia Foundation: July 25–30

For children with a bleeding disorder and their siblings | Fee: \$25, refundable once camper attends. VA Chapter of National Hemophilia Foundation fundraises to pay for the camp experience but to help CHT defray the cost of food we do require that all Camp Youngblood families fill out the attached "Campership + Summer Meals" Form

SESSION 5 – FAMILY CAMP WEEK: August 1 - 6

For families with children with special health needs | Fee: \$600 per family of 4, \$30 for each additional person. Please contact CHT for Family Camp Application Forms & more information.

CAMP KESEM: August 8 – 14

Please visit www.campkesem.org/uva for information and application | Fee: None

How did you hear about Camp Holiday Trails?

Has your child ever attended Camp Holiday Trails before? Yes No If yes, what year(s)? _____

DIAGNOSIS INFORMATION

Please select a group which best fits your child:

- | | | | |
|---|---|--|---|
| <input type="radio"/> Asthma | <input type="radio"/> Cerebral Palsy | <input type="radio"/> GI Disorder | <input type="radio"/> Sickle Cell Disease |
| <input type="radio"/> Bleeding Disorder | <input type="radio"/> Craniofacial Disorder | <input type="radio"/> Immunology (ex. HIV) | <input type="radio"/> Skin disease |
| <input type="radio"/> Cancer | <input type="radio"/> Diabetes | <input type="radio"/> Kidney Disease | <input type="radio"/> Spina Bifida |
| <input type="radio"/> Cardiac Disease | <input type="radio"/> Epilepsy | <input type="radio"/> Rheumatic (ex. JRA, SLE) | <input type="radio"/> Other, list: _____ |

Siblings (Young Camper Week and Camp Youngblood only): Please contact camp for a *Sibling Application*

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CAMPER NAME: _____

If you have any questions or need any assistance while completing this application, our staff is here to help! Just call (434-977-3781) or e-mail us (ashley@campholidaytrails.org).

PRIMARY Diagnosis: _____

SECONDARY/ADDITIONAL Diagnosis: _____

MOBILITY ISSUES: Does your child use/have any of the following? (Please check all that apply):

None Wheelchair Crutches Splint Braces Artificial Limb

Other, please describe: _____

ALLERGIES:

Does your child have any FOOD, DRUG, INSECT, LATEX, or OTHER allergies? Yes No

If yes, please specify use the GRID below to identify & describe.

ALLERGY (Food, Drug, Latex, Insect)	REACTION (*Please note if ANAPHYLACTIC*)	TREATMENT

SPECIAL DIETARY NEEDS: Does your child have any special dietary needs? Yes No

If yes, please describe: _____

CONTACT INFORMATION



Camper Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Caregiver/Guardian Information

(Please check preferred contact telephone #)

MOTHER/GUARDIAN Name: _____ Home Ph. # (____) _____

E-mail: _____ Cell Ph. # (____) _____

Alternate/Work Ph. # (____) _____

FATHER/GUARDIAN Name: _____ Home Ph. # (____) _____

E-mail: _____ Cell Ph. # (____) _____

Alternate/Work Ph. # (____) _____

Who has legal custody of this child? _____ Relationship? _____



Emergency Contact Information: Someone **other than a parent or guardian** must be available for questions and emergency pick-up **at all times** your child is at camp.

EMERGENCY CONTACT Name: _____ Home Ph. # (____) _____

Cell Ph. # (____) _____

Alternate/Work Ph. # (____) _____

GENERAL INFORMATION
(To be completed by Parent or Guardian)



PRIMARY CARE PHYSICIAN's Name: _____ Ph. # (____) _____

Address: _____ Emergency Ph. # (____) _____

Fax Ph. # (____) _____

SPECIALIST's Name: _____ Ph. # (____) _____

Hospital Affiliation (if applicable): _____ Emergency Ph. # (____) _____

Fax Ph. # (____) _____



Does your child have any medical challenges other than his/her primary/secondary diagnosis? (Examples: asthma, constipation, sleepwalking, hearing or vision loss, bed wetting, developmental delay, etc.)

Yes No If yes, please explain: _____

Does your child **require physical assistance** (include help with dressing and hygiene) at home or in school?

Yes No If yes, please identify level of assistance: Minimal Moderate Needs 1:1 Assistance

Please give examples: _____

How does your child **make his/her needs known**? How do you communicate with him/her? _____



Camp Holiday Trails plans activities for children ages 7 – 17. **Campers must have a cognitive level within 1 or 2 years of their actual age.** At what age does your child function? (Please consider how your child functions at school or in interactions with his/her peers)

Younger than 7 Age 7 – 8 Age 9 – 10 Age 11 – 12 Age 13 – 14 Age 15 – 17



It is important to us that we get to know each child **before** they come to camp. Please answer the following questions about your child's interests, home life, and behavior so that we are aware of all of your child's needs.

What are your **child's favorite activities** (books, music, etc.)? _____

Have there been **any significant changes in your child's home life** over the past year (i.e. – moving, separation, divorce, adoption, death in the family, loss of employment, etc.)? Yes No

If yes, please explain: _____

How does your child behave in **non-classroom settings** (i.e. – PE, recess, art)? _____


CAMPER NAME: _____

Has your child ever been suspended from school or faced **disciplinary action**? Yes No

If yes, please explain: _____

Has your child ever **harmed him/herself or others**? Yes No If yes, please explain: _____

Has your child ever talked about or actually **run away**? Yes No If yes, please explain: _____

 Is there **any other information we should know** that will help us provide a more enriching experience for your child? Any medical challenges you would like our Med Staff to help your child manage?

I have completed this application to the best of my knowledge. I understand that incomplete or inaccurate information may result in the inability of this camper to participate in the Camp Holiday Trails program.

Name of person who completed this application: _____

Relationship to applicant: _____ Date _____



Camp Holiday Trails accepts children with a history of blood borne pathogens, including HIV. We practice strict universal precautions and maintain appropriate medical record confidentiality.

CAMPER HEALTH FORM

(To be completed by a Physician or Medical Professional)

Page 7 of 10

A Physician or Medical Professional must complete the camper health form on the following pages before submitting this application and it must be dated within 6 months of camp.

TODAY's Date: _____

CAMPER's Name: _____

CAMPER's DOB: _____

GENERAL INFORMATION



PRIMARY Diagnosis: _____ Date of Dx: _____

SECONDARY Diagnosis: _____

DRUG Allergies: _____

Other allergies and significance (latex, bee stings, peanuts, etc.): _____

PHYSICAL EXAM



Height _____ ft _____ in Weight _____ lb Blood Pressure _____

Pertinent Findings: _____

MEDICATIONS – Routine and PRN (attach additional sheet if necessary)

MEDICINE NAME	DOSE	ROUTE	FREQUENCY

Is this child currently receiving ongoing treatment? Yes No If yes, please explain: _____

How is this child affected by his/her diagnosis? (Please list any physical limitations): _____



Please list any SURGERIES: _____

HOSPITALIZATIONS within the last 12 months: _____

Braces, wheelchair, or other mobility challenges? Yes No If yes, please explain: _____

Has this child had his/her appendix removed? Yes No



Special DIET/NUTRITION Requirements: _____

If this child routinely receives LAB WORK, please attach most recent lab results.

Please list any essential labs to be performed while child is at camp: _____

Is this child developmentally appropriate for his/her age? Yes No

If NO, at what (approximate) age does the child function: _____

REQUIRED IMMUNIZATION RECORDS



Camp Holiday Trails follows the American Academy of Pediatrics' guidelines for camps in determining these requirements.

IMPORTANT – Camp Holiday Trails **requires** the following immunizations in order for a child to attend camp. Please help us by completing the following section in its entirety:

- ☞ 5 doses of **DTaP** (diphtheria, tetanus & pertussis) Dates: _____
- ☞ If over 11 years, must also have **TDaP** (tetanus, diphtheria & pertussis). Date: _____
- ☞ If over 11 years, must have **Menactra** (meningococcal vaccine). Date: _____
- ☞ 4 doses of **IPV** (polio vaccine). Dates: _____
- ☞ 2 doses of **MMR** (measles, mumps & rubella). Dates: _____
- ☞ This child has had chickenpox. Date: _____ If not: _____
- ☞ 2 doses of **Varivax** (chickenpox vaccine) Dates: _____
- ☞ 4 doses of **Prevnar** (pneumococcal conjugate vaccine). Dates: _____
- ☞ 3 doses of **Hepatitis B** vaccine. Dates: _____
- ☞ If NO to any of above, please explain: _____
- ☞ If tested for **HIV**, status: _____

(NOTE: Children who are HIV+ are not required to receive MMR and Chicken Pox vaccines.)

Check here if you have included a Doctor's copy of your Immunization record in lieu of filling out the above section

SUPPLEMENTAL HEALTH FORM

Please complete the following Supplemental Health information for all G-TUBE, CATHETERS, CENTRAL LINES, DIABETES, EPILEPSY, HEMODIALYSIS, HEMOPHILIA, HIV, and KIDNEY DISORDERS. *If none apply, please proceed to page 9 (last page) for required MEDICAL/PROFESSIONAL SIGNATURE!*

G-TUBE/TPN

Manufacturer and model of pump: _____

Type of supplemental nutrition: _____

CATHETER, Central Venous & CENTRAL LINES

Type of Catheter (Single/Double Lumen, Hickman, Broviac, Groshing, PICC, Portacath): _____

Instructions for Catheter Care

How often is it flushed with Heparin? _____

Amount and strength of Heparin? _____

How often is the dressing changed? _____ When is the catheter changed (days of week)? _____

Special Instructions: _____

This child DOES DOES NOT have permission to swim in a chlorine-treated pool. (Dressings changed immediately after swimming). *Please note that we do swim each day at camp.*

CATHETER, Urinary

What size? _____ Brand? _____

Indwelling or in/out: _____ If indwelling, how often do you change: _____

If in/out, how often do you cath? _____

DIABETES Type 1 Type 2

A1c: _____ % Current meter name: _____ If on insulin pump, pump name: _____

Does child administer own injections? Yes No

Insulin type (NPH, Humalog, etc.): _____ Oral meds: _____

of Injections per day: _____ Is child counting carbs? Yes No

History of diabetes-related problems (DKA, etc.): _____

EPILEPSY/SEIZURE DISORDERS

Seizure type: _____ Frequency: _____

Last seizure: _____ Typical Length: _____

What might bring on a seizure? _____

HEMODIALYSIS

Home dialysis unit name: _____ Phone (_____) _____

(NOTE: UVA dialysis unit will have an additional form with detailed information that will be sent to all hemodialysis patients.)

For our Med Staff at camp -

Please list target weight: _____ Average weight gain: _____

Average pre-dialysis BP: _____ Average post-dialysis BP: _____

Fistula or catheter: _____ Location: _____

HEMOPHILIA or BLEEDING DISORDER

Bleeding disorder diagnosis: _____

Special considerations (Inhibitor, etc.): _____

Current treatment (pretreatment/replacement therapy, prophylaxis, immune tolerance, etc.) INCLUDE TYPE OF FACTOR, DOSAGE & SCHEDULE (Factor VIII for hemophilia A or Factor IX for hemophilia B):

How will child need to be "factored" while at camp? _____

Target Joints: _____

Does child administer own infusions? Yes No Last HTC Visit: _____

HIV

Is child aware of positive status? Yes No

Most recent or typical blood counts (DATE: _____):

Hb _____ Hct _____ WBC _____ ANC _____ Plt _____

CD4+ Cell Count % _____ Viral Load Copy _____

KIDNEY DISORDERS/RENAL

Kidney diagnosis: _____

Diet/Fluid restrictions: _____

Average BP: _____ How frequently is BP monitored? _____

If Nephrotic:

Average weight in remission: _____ Frequency of urine testing: _____ Last relapse: _____

PHYSICIAN/MEDICAL PROFESSIONAL RECOMMENDATION

Based on my knowledge of this patient, _____, YES this child should be considered for acceptance at Camp Holiday Trails. I have examined this child and find him/her physically able to attend camp. I understand that the above medical program will be followed while he/she is at camp. If necessary, I will work with Camp Medical Staff to meet this child's needs.

If you are NOT recommending this child, please explain: _____

Provider's Signature *Print Name* *Date*

Clinic Name *Hospital Affiliation*

(_____) _____ (_____) _____ (_____) _____
Phone *Emergency/On Call Phone* *Fax*



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Camp Holiday Trails' mission is to **empower, encourage, and educate** children with chronic illnesses, their families, and healthcare professionals by providing a summer camp and year-round programming aimed at personal growth.

CAMPER ASSESSMENT FORM

*(To be completed by **Social Worker, Guidance Counselor, Therapist or Teacher**)*

All Information in this form will be treated as personal and confidential



The person who asked you to complete this form is applying to attend Camp Holiday Trails (CHT). CHT is a special place that gives children with chronic illnesses and special medical needs the chance to experience a traditional camp. Our Med Staff work 24 hours a day in an on-site clinic and we have one adult counselor for every three campers. In all other respects, CHT is a traditional summer camp, with all the outdoor summer activities children love – and opportunities to develop self-confidence, build self-esteem, foster independence and better manage their healthcare. **Campers should function cognitively within 1 or 2 years of their actual age** and be, for the most part, independent.

Your cooperation and accuracy with the completion of this form will ensure a positive camp experience for all of our campers and will enable the camp to make an appropriate individualized assessment of the applicant's abilities.

Please mail or fax this form directly back to Camp Holiday Trails ASAP. Thank you!



Your Name: _____ Title: _____

Daytime Phone #: (_____) _____ Evening Phone #: (_____) _____

E-mail: _____



Child's Name: _____ Age: _____ Grade: _____

In what capacity do you know this child? _____

How long have you know this child? _____

How often do you see this child? _____

Describe your interactions with this child: _____

How does this child respond to **limits or directions** from you? _____

From others? _____

How does this child **view his/her overall health**? _____

What have you observed of this child's **ability to care for his/her medical condition**? _____

Does this child exhibit any *fears or phobias*? _____

Do you have any *behavior concerns* about this child? Yes No If yes, please explain: _____

How does this child *interact with his/her peers*? _____

Have you observed *emotional outbursts* from this child? Yes No If yes, please explain: _____

How does this child behave in *non-classroom settings* (i.e. – PE, recess, art)? _____

Has this child ever been suspended from school or faced *disciplinary action*? Yes No
If yes, please explain: _____

Has this child ever *harmed him/herself or others*? Yes No If yes, please explain: _____

Has this child ever talked about or actually *run away*? Yes No If yes, please explain: _____

Overall do you consider the applicant to be: (check ALL that apply)
 Emotionally immature Mature Shy Outgoing Age Appropriate

Is this child *developmentally appropriate* for his/her age? Yes No
If NO, at what (approximate) age does this child function: _____

What role can we play in fostering or increasing this child’s sense of independence? _____

Would you recommend this child for a residential/overnight camp experience?
 Yes, absolutely Yes, with some reservation Possibly No
If no, please explain: _____

Please provide us with any additional pertinent information regarding this child: _____



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We work hard all year-round to raise the funds needed to allow each child to attend Camp. We DO ask our families to partner with us and TOGETHER we will send your child to Camp!



Camp fees: We understand the challenges our camp families face each and every day. While the cost of attending Camp Holiday Trails remains \$1,120 for 2 weeks (\$560 for 1 week session), this year we are again able to accept a minimum of \$120 per camper thanks to our generous donors and fundraising efforts.

\$120

Complete the attached form and we will accept \$120 (1 or 2 wks) for each camper, regardless of your household income. Our fundraising will cover the rest. Financial aid has already been applied. Note: no fee for Camp Youngblood sibs, but Summer Meals form still required!

Need more help?

If you need assistance: Contact Camp for a sample letter to give to an employer, school, church, neighbors, family, friends, or anyone who can help you get to camp!

Help other kids?!

If you have the ability to pay more, please know that we encourage families to try and come closer to the full \$1,120 fee! We are counting on you to help spread our dollars and help more kids attend Camp!

**EVERYONE Must Complete & Submit:
The Campership & Summer Meals form and Camper Assessment!**

**ATTACHED:
Campership Application & Summer Meals for Kids**

**Application forms also available online:
www.campholidaytrails.org**

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Camp Holiday Trails

A Camp for Children with Special Health Needs



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campisgood@campholidaytrails.org
www.campholidaytrails.org

CAMBERSHIP & SUMMER MEALS FOR KIDS APPLICATION 2010 *ALL CAMPERS*

Camp Holiday Trails (CHT) is a non-profit, 501(c)3 camp for children with special health needs. We are committed to making our camp available to as many children as possible, regardless of ability to pay. Each year we work hard to raise funds through special events, grants and private contributions.

We understand that providing the best possible program and care for your child *requires an investment*. We ask parents to complete the **Campership Application and Summer Meals for Kids form** accurately and honestly so that we may use our funds to provide *as many children as possible* with the Camp Holiday Trails experience. All information is confidential.

1. Camper Name:

Last name _____

First Name _____

New Camper

Returning Camper

Foster Child? YES NO If yes, child's monthly personal income: \$ _____

(Go to #5.)

3. Food Stamps, TANF or FDIPIR benefits. Please list **CASE #**.

Food Stamp case #: _____ TANF case #: _____ FDIPIR case #: _____

(Go to #5.)

4. ALL OTHER HOUSEHOLDS (Complete this section only if you did not complete #2 or #3.)

Names of Household Members (include child above)	Monthly Earnings from Work, Job 1 (before deductions)	Monthly Welfare, Child Support, Alimony	Monthly Payments from Pensions, Retirement, Social Security	Monthly Earnings from Job 2 or Any Other Monthly Income
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

5. I certify that all of the above information is true and correct and that the food stamp, TANF, FDPIR or other eligible program case number is current, correct or that all income is reported. I understand that this information is being given for the receipt of Federal funds (Summer Meals for Kids) and that institution officials may verify the information and that the deliberate misrepresentation of information may subject me to prosecution under applicable State and Federal law.

Signature of Adult: _____ Social Security #: _____

Print Name: _____ Home Ph.: _____ Work Ph.: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Date: _____

Privacy Act Statement: Unless you list the child's food stamp, FDPIR or TANF case # or are applying for a foster child, Section 9 of the National School Lunch Act requires that you include the social security # of the household member signing the form or indicate that the household member signing the form does not have a social security #. You do not have to list the social security #, but if the social security # is not listed, or an indication is not made that the adult household member signing the form does not have a social security #, we cannot approve the form. The social security # may be used to identify the household member in verifying correctness of information stated on the form. This may include program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp, FDPIR or TANF office to determine current certification for food stamps, FDPIR or TANF benefits, contacting the State employment security office to determine the amount of benefits received, and checking documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The social security # may also be disclosed to programs as authorized under the National School Lunch Act and the Child Nutrition Act, the Comptroller General of the US, and law enforcement officials of investigating violations of certain Federal, State and local education, health and nutrition programs.

The US Dept. of Agriculture (USDA) prohibits discrimination in all of its program and activities on the basis of race, color, national origin, gender, age or disability. Person with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD.)

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Rm. 326-W, Whitten Bldg., 14th & Independence SW, Wash., DC 20250-9410 or call (202) 720-5964 (voice and TDD.) USDA is an equal opportunity provider and employer.

FOR OFFICE USE ONLY:

Food Stamp/TANF/FDPIR or other eligible program benefit eligibility: YES NO

If NO, Monthly Income Conversion:

Total monthly income: \$ _____ Household size: _____ Eligible: YES NO

Determining official: _____ (print)

_____ (signature) Date: _____

CAMP FEE

Our fees are used to maintain a safe camp, to keep our counselor:camper ratios low, to provide housing for MDs to live at Camp, to stock and staff Med Korner, to feed every Camper 3 meals and 3 snacks a day ...

Please remember, we are a CHT family. Give when you can to help others. You know their challenges.

**I will be paying the \$120 fee: \$120
(for 1 OR 2 wk camps as 1 wk camps are smaller with different staff ratios)**

I can pay this add'l amount towards the fee so that the fin. aid available can be used to send more kids to Camp: \$ _____

**Amount CHT will contribute: \$ _____ (office use only)
TOTAL CAMP FEE \$120 (2-weeks) \$560 (-week)**