2020 Telomere Biology Disorders / Dyskeratosis Congenita
Camp Information

Thank you for your interest in attending Camp Sunshine. Pages 1–3 of the application are for families to complete. Pages 4 – 6 are for your hematology team to complete.

Eligibility Guidelines

- If both parents are unable to attend, a second adult may attend as a support person and should be included on the application.
- Immunization records are required for everyone under 26 years of age.
- Completed applications will be reviewed on a first-come, first-served basis, and should be received at least one month prior to the session start date. (If seeking to apply within one month of the program, please call Camp Sunshine to inquire about availability.)
- Families may attend one session per program year.

Things to Know About Camp

- Meals, lodging, and activities are all provided at no cost to families thanks to the generosity of our donors.
- A pediatric physician is present on-site during all Camp Sunshine sessions.
- Family suites can comfortably sleep 6 and include a private bathroom, heat/AC, a mini-fridge, and microwave oven.
- Transportation assistance may be available for families who would otherwise be unable to attend Camp. Funding is prioritized for families attending for the first time. Please indicate your request for transportation funding on the first page of the application. If funding is requested, you will receive further information at the time of acceptance.
- You will be contacted when your application is processed. Acceptances and other updates will be provided as soon as possible.

Applications may be mailed or faxed to:
Camp Sunshine
35 Acadia Road
Casco, ME 04015
Phone: (207) 655-3800
Fax: (207) 655-3825
www.campsunshine.org
2020 Telomere Biology Disorders / Dyskeratosis Congenita
Application Checklist

Please use the following checklist to ensure that your family’s application is complete.

☐ Family Forms
- Pages 1-3 of the application, to be completed by the parent/guardian

☐ Physician Forms
- Pages 4-6 of the application, to be completed by the TBD / DC camper’s specialist

☐ Immunization Records
- A complete and up-to-date immunization record must be included for each person under 26 years of age who is applying to attend Camp.
- For the optimal health and safety of all campers, staff, and volunteers, Camp Sunshine requires that all campers who can receive immunizations meet the age-appropriate immunization schedule as set forth by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
- At a minimum, campers aged 5 years and older should meet the same immunization requirements as those for school-aged children set forth in the State of Maine School Immunization Law (20-A MRSA §§6352-6358):
  - 5 DTaP (4 DTaP if the 4th is given on or after the 4th birthday)
  - 4 Polio (if the 4th dose is given before the 4th birthday, an additional age-appropriate inactivated polio immunization should be given on or after the 4th birthday)
  - 2 MMR (measles, mumps, rubella)
  - 1 Varicella (chickenpox) or reliable history of disease
- Camp Sunshine also requires that children aged 11 and older receive meningococcal vaccine and TDaP booster prior to attendance.

☐ Health History Forms
- A separate Health History form is required for each person (including adults) planning to attend Camp, with the exception of the child with TBD / DC. The Health History forms do not require a physician signature.
A retreat for children with life-threatening illnesses and their families

2020 Telomere Biology Disorders / Dyskeratosis Congenita Program
September 10 – 15 2020
Family Application

Please print clearly using black or blue ink.

CAMPER INFORMATION

TBD / DC Camper’s Last name ____________________  TBD / DC Camper’s First Name ____________________
Gender ______________________________________  Date of Birth _____/_____/_______
Diagnosis ____________________________________  Date of Diagnosis _____/_____/_______
Address _____________________________________  Apt ______  City ______________  State _____  Zip _______
Home telephone ________________________________  E-mail ________________________________

Treatment Center ____________________________________________
Address ______________________________________________  City ______________  State _____  Zip _______

Physician (Specialist) ____________________________________________  Telephone ________
Social Worker ____________________________________________  Telephone ________
Child Life Specialist ____________________________________________  Telephone ________

Health Insurance Company ________________________________  Telephone ________________
Policy Holder ____________________________________________  Policy No. ________________  Group No. ________________

Prior Attendance – This will be our (please circle one) 1st time  2nd time  3rd time  4th time  ____ th time at Camp.
How did you hear about Camp Sunshine? Name ____________________________________________

□ Check to Request Travel Assistance

Family Forms  □ Immunizations  □ Physician Forms  □ Health History Forms

(3/12/2020) 1
INFORMATION FOR FAMILIES WITH CHILDREN UNDER AGE 18

Name of parent(s) or guardian(s) camper lives with: _____________________________________________

Marital status (please indicate marital status of parents and explain any particular familial circumstances and/or custodial arrangements of which we should be aware): __________________________________________________________

Parent/Legal Guardian 1 ___________________________ Parent/Legal Guardian 2 ___________________________
Relationship to child ___________________________ Relationship to child ___________________________
Date of Birth ____/____/____ ______________________ Date of Birth ____/____/____ ______________________
Address ______________________________________ Address: ________________________
City, State, Zip __________________________________ City, State, Zip ____________________________
Home Phone ________________________ Cellular phone ________________________
Cellular phone ________________________ E-mail ______________________________________
Employer _____________________________________ Employer: ________________________
Have you been in the Armed Forces? □ Yes □ No Have you been in the Armed Forces? □ Yes □ No
Have you been in the Reserves? □ Yes □ No Have you been in the Reserves? □ Yes □ No

Emergency Contact (someone who will not be attending Camp with you)
Name ____________________________________ Relationship ____________ Telephone ____________

WHO WILL BE ATTENDING CAMP WITH THE TBD / DC CAMPER?
One adult support person may permitted to accompany a single parent/guardian or a parent/guardian whose partner cannot attend.

Adults'/Parents'/Legal Guardians' Names ___________________________ Relationship to TBD /DC Camper ___________________________
Medical or Emotional diagnosis or concern? □ No □ Yes
If “Yes,” please explain and include on Health History Form __________________________________________

Sibling's/ Camper’s Children/ Support Person’s Child(ren)’s Names ___________________________
Relationship/ Age at time of Camp ___________________________
Medical or Emotional diagnosis or concern? □ No □ Yes
If “Yes,” please explain and include on Health History Form __________________________________________

1.________________________________________________________________________________________
   Date of Birth ____/____/____ Age at time of Camp ________/____yr
   □ No □ Yes

2.________________________________________________________________________________________
   Date of Birth ____/____/____ Age at time of Camp ________/____yr
   □ No □ Yes

3.________________________________________________________________________________________
   Date of Birth ____/____/____ Age at time of Camp ________/____yr
   □ No □ Yes

4.________________________________________________________________________________________
   Date of Birth ____/____/____ Age at time of Camp ________/____yr
   □ No □ Yes

5.________________________________________________________________________________________
   Date of Birth ____/____/____ Age at time of Camp ________/____yr
   □ No □ Yes

6.________________________________________________________________________________________
   Date of Birth ____/____/____ Age at time of Camp ________/____yr
   □ No □ Yes

*PLEASE NOTE: ALL CHILDREN UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY A PARENT AND/OR LEGAL GUARDIAN WHEN ATTENDING CAMP. IF A LEGAL GUARDIAN WILL BE ACCOMPANYING A CHILD TO CAMP, ORIGINAL NOTARIZED DOCUMENTATION CONFIRMING THE GUARDIANSHIP MUST BE INCLUDED WITH THIS APPLICATION. IF MARITAL STATUS IS SEPARATED OR DIVORCED, PARENTS/ LEGAL GUARDIANS MAY BE REQUIRED TO PROVIDE ADDITIONAL INFORMATION.

TBD / DC CAMPER’S GENERAL MEDICAL HISTORY

THE MORE INFORMATION WE HAVE, THE BETTER UNDERSTANDING WE WILL HAVE OF THE CAMPER’S NEEDS.

Primary language: __________________________ Secondary Language: __________________________

Additional medical problems (allergies, asthma, diabetes, etc.): __________________________________________

Drug allergies: __________________________

Dietary restrictions or food allergies: __________________________________________

Does your child have joint pain? □ Yes □ No  Physical limitations: __________________________________________

Mobility (e.g., wheelchair, crutches, amputation): __________________________________________

Special needs/care requirements (vision/hearing loss): __________________________________________

Does the TBD / DC camper have seizures? □ Yes □ No  If so, how frequently do they occur? __________________________________________

Please describe the type of seizure: __________________________________________

What treatment is necessary for the seizures? __________________________________________

When was the last seizure? __________________________________________

Is the TBD / DC camper incontinent? □ Yes □ No  If yes: □ Bladder □ Bowel  Is catheterization needed? □ Yes □ No

Please describe any support the TBD / DC camper receives at school or elsewhere for developmental, behavioral, social-emotional, or functional living needs: __________________________________________

(3/12/2020) 2
Permission to use photographs, video tape and/or audio tape of you and/or your family

On behalf of myself and my family, I hereby give Camp Sunshine, without consideration or compensation, permission to use photographs, videotape, and/or audiotape that may be taken or recorded while my child and family are attending Camp for promotional, educational, or fundraising activities. It is my understanding that these likenesses may be used to promote public and professional understanding and support of the program. I waive any right that I may have to inspect or approve the finished product or the use to which it may be applied.

Parent/Guardian/Other Adult ___________________________ Signature ___________________________ Date ____________

Permission to use photographs and/or videotape of you and/or your family for postings on Social Media.

On behalf of myself and my family, I hereby give Camp Sunshine, without consideration or compensation, permission to use photographs and/or videotape that may be taken or recorded while my child and family are attending Camp for postings on social media including but not limited to postings on Camp Sunshine at Sebago Lake's official Facebook page. I waive any right that I may have to inspect or approve the finished product or the use to which it may be applied.

Parent/Guardian/Other Adult ___________________________ Signature ___________________________ Date ____________

Permission to use family name in connection with fundraising efforts

I give my permission for Camp Sunshine to use my/my family's name to help raise funds to support the Camp Sunshine program. I understand that I am to receive no compensation for the use of my/my family's name for these purposes.

Parent/Guardian/Other Adult ___________________________ Signature ___________________________ Date ____________

Authorization for Camp Sunshine to provide Medical Treatment

I hereby give my consent for Camp Sunshine’s medical personnel to provide any and all reasonable and necessary medical treatment for my children.

(Please include all of the children in your family who will be attending Camp Sunshine).

<table>
<thead>
<tr>
<th>Children's Names</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
</tr>
</tbody>
</table>

This authorization shall remain in effect while we are attending Camp Sunshine at Sebago Lake in Casco, Maine.

Parent/Guardian/Other Adult ___________________________ Signature ___________________________ Date ____________

I understand and agree that information disclosed regarding any of the individuals named in this application and related documents may be disclosed or otherwise released to appropriate organizations or individuals (including, but not limited to: members of the Camp Sunshine staff, insurance companies, and physicians) in connection with attendance at Camp Sunshine at Sebago Lake, Inc. I hereby confirm that the above information is true and accurate and that once accepted, I agree to update this information as you may request.

I understand that Camp Sunshine reserves the right to accept or decline any application for any reason.

Parent/Guardian/Other Adult ___________________________ Signature ___________________________ Date ____________
Physicians’ Guidelines for Camp Sunshine Applications

The medical guidelines for patients who wish to attend Camp Sunshine are as follow:

1. Campers are considered medically acceptable to participate in the program if they can be expected to be in good general health at the time of the camp session. Children should not attend camp if they are entering into an anticipated period of significant myelosuppression. We regret that we cannot accommodate patients with renal disease who are on hemodialysis.

2. Campers should undergo laboratory testing, when appropriate, prior to attending camp. A “Late Changes” form is to be sent to Camp 1-3 weeks in advance of the patient’s attendance, noting up-to-date laboratory tests and medication changes.

3. The Physical Examination form must be completed by the camper’s subspecialty team and returned along with the camper’s application.

4. Campers should not require any therapy during Camp other than treatment usually administered at home, with the exception of methotrexate or colony stimulating factors.

5. Campers should not require any form of special medical care during the week of Camp, e.g. transfusions.

6. Arrangements for laboratory investigations at Camp should be made in advance by the referring physician, or by the family with the Camp physician upon arrival.

7. **Children or other susceptible family members who have been exposed to varicella (chickenpox) within three weeks of a camp session cannot attend. In the event that a child or other family member has been exposed to herpes zoster (shingles), please contact Camp for further guidance.**

8. **Children or family members who have received oral polio vaccine within six weeks of a camp session cannot attend.**

If a camper does not meet these guidelines, please contact the Camp Sunshine office directly so the situation can be further assessed.

It is the intent of Camp Sunshine to provide respite for your patients and their families with as little medical intervention as possible. A pediatric physician will be present at Camp to provide evaluation of acute problems. No treatment will be offered at Camp other than management of routine childhood illnesses and minor injuries. Transportation will be provided to a nearby medical facility in the event that other treatment is necessary. It is not the intent of Camp Sunshine to provide routine medical care for other family members.

Thank you for helping us to provide a unique respite experience for your patients and their families. It is our expectation that children will be qualified as acceptable for referral by their own treating physicians with the above specifications in mind. Children who do not meet the above guidelines will find it inconvenient to receive needed medical care in this setting and should not be encouraged to attend. Please contact the Family Coordinator with any questions regarding the above or any aspect of medical support available for Camp participants at 207-655-3800 between 8:30am and 4:30pm Monday through Friday.

Please submit a fully completed application to:

Camp Sunshine
35 Acadia Road
Casco, ME 04015

Phone: (207) 655-3800    Fax: (207) 655-3825
http://www.campsunshine.org
CAMP SUNSHINE TELOMERE BIOLOGY DISORDER / DC PHYSICAL EXAMINATION FORM

The following information should be provided by the pediatric hematology team treating the child.

Please return to Camp Sunshine: 35 Acadia Road, Casco, Maine 04015 P: (207) 655-3800 F: (207) 655-3825

THIS APPLICATION CANNOT BE PROCESSED UNTIL ALL THE INFORMATION BELOW IS COMPLETE.

Patient’s Name: ___________________________ Date of Birth: ____ / ____ / ____
Diagnosis: __________________________________ Date of Diagnosis: ____ / ____ / ____
Allergies: _________________________________ Date of Examination: ____ / ____ / ____

1. Telomere Biology Disorder / Dyskeratosis congenita
   Is the patient on active treatment?  ☐ Yes  Dates and nature of most recent therapy: ______________________________
   ☐ No  Date therapy completed: ____/____/____

   Describe any recent admissions or serious illnesses: ______________________________

   Has the patient been under the care of a psychiatrist? ☐ Yes ☐ No  Please describe any behavioral, social, emotional, or psychiatric issues that may affect the patient: ______________________________

2. Central venous access
   Type of access: ☐ External (Broviac/Hickman) ☐ Internal (Portacath/Infusaport/Mediport) ☐ Not applicable

   Special instructions regarding central line/port: __________________________________________________________

3. Is the Child Permitted to Participate in the Following Activities at Camp:
   Swim in a chlorinated indoor heated pool?  ☐ Yes ☐ No
   Swim in lake water?  ☐ Yes ☐ No
   Engage in contact sports?  ☐ Yes ☐ No
   Climb on our climbing wall?  ☐ Yes ☐ No
   Participate in high elements on our ropes course?  ☐ Yes ☐ No

   Are there any restrictions or suggestions for this child? __________________________________________________

   Describe any disability or physical limitations affecting other camp activity: ______________________________

4. Transfusions
   Is the patient on a transfusion protocol?  ☐ Yes ☐ No  Is the patient likely to require transfusion during camp?  ☐ Yes ☐ No

   Has the patient ever had a transfusion reaction?  ☐ Yes ☐ No  Transfusion history of note __________________________

   What are guidelines for transfusion? ______________________________________________________________

   What preparation or pre-medication is required? _____________________________________________________

5. Bone Marrow/Stem Cell Transplantation
   Has the child undergone bone marrow/stem cell transplantation?  ☐ Yes ☐ No  If yes: ☐ autologous ☐ allogeneic

   Date of transplant ____ / ____ / ____  Have there been any complications related to the transplant?

6. Varicella (If the following information is not complete, this application cannot be reviewed.)
   Please indicate:
   _____ (1) This patient is IMMUNE to varicella by reason of (check one or more):
   ☐ clinical disease  ☐ positive titer  ☐ Varivax vaccine  – OR –
   _____ (2) This patient is NOT IMMUNE to varicella and the vaccine has not been administered to him/her.

IN THE EVENT OF A VARICELLA EXPOSURE AT CAMP, WILL THIS PATIENT REQUIRE VARIZIG AND/OR ACYCLOVIR? ☐ YES ☐ NO
PHYSICAL EXAMINATION

Height: ________     Weight: ________     Pulse: ________     Respirations: ________     BP: _____/_____

Please note all abnormal findings. Check “✓” indicates normal.

HEENT ____________________________________ Musculoskeletal/Back _______________________
Neck ______________________________________ Genitalia _________________________________
Lungs ______________________________________ Neurologic ______________________________
Heart ______________________________________ Skin ______________________________________
Abdomen __________________________________ Prostheses? ______________________________

Comments: ____________________________________________________________________________

LABORATORY INVESTIGATIONS

Date: _______ H/H _____/_____ WBC ________ (ANC ________) Platelets ________
Chemistries: ___________________________________________________________ Urinalysis: __________

Will the patient require laboratory tests while at camp? If so, please specify which tests and to whom results should be called/forwarded. (Please limit these to essential studies.) ________________________________

MEDICATIONS*

WITH THE EXCEPTION OF WEEKLY METHOTREXATE, CHEMOTHERAPY IS NOT ADMINISTERED AT CAMP.

Please list medications that the patient receives routinely (include pain management). Attach additional pages if necessary.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Each family should bring all medications, catheter dressings, and other necessary supplies.

IS THERE ANYTHING ELSE WE SHOULD KNOW THAT WOULD BETTER ASSIST US IN PREPARING FOR THIS FAMILY TO ATTEND CAMP? IN PARTICULAR, ARE THERE ANY SOCIAL OR EMOTIONAL CONCERNS PERTAINING TO ANY FAMILY MEMBER?

The patient’s next appointment is due: ________________________________________________

PLEASE NOTIFY US OF ANY UPDATES (I.E., MEDICATIONS, LAB RESULTS) ON A LATE CHANGES FORM.

We regret that applications cannot be reviewed unless the signature of the attending hematology physician is provided below. Thank you for your cooperation!

I have examined ___________________________ who is physically able to engage in camp activities except for the limitations and restrictions noted above.

Attending physician’s/nurse practitioner’s signature: __________________ Date ________________
Type/print name: ________________________________________________________________
Address: ______________________________________________________________________
Telephone: (____) __________________ Fax: (____) ________________________________
Telephone or pager where health professional who is familiar with the patient can be contacted at night and on weekends: (____) ______________________
Health History Form

Please complete pages 1 and 2 of this form for each person attending other than the camper. Information must be filled out by a parent/guardian for all minors. Any changes to this form should be provided to Camp Sunshine staff prior to arrival.

Name __________________________     Birth date ___________     Age: _______   Gender: ___________________

Parent/guardian (if applicable) ____________________________

Name (in full) as you would like it to appear on the nametag ___________________________________________

Address ___________________________     City _______________________     State ________     Zip ________

Insurance Information
Is the participant covered by family medical/hospital insurance? □ yes   □ no
Carrier or plan name _________________________     Policy No. ____________     Group No. ______________

Medications
Please list all medications taken routinely. Bring enough medication to last the entire camp session. Keep all medication in original packaging/bottle that identifies the prescribing drugs.

Med #1_____________________Dosage_____________Specific times taken each day__________________
Reason for taking____________________________________

Med #2_____________________Dosage_____________Specific times taken each day__________________
Reason for taking____________________________________

Med #3_____________________Dosage_____________Specific times taken each day__________________
Reason for taking____________________________________

General Questions (Explain “yes” answers)
1. Have you had any recent injury, illness, or infectious disease? □ yes   □ no
2. Do you have a chronic recurring illness/condition? □ yes   □ no
3. Have you ever been hospitalized? □ yes   □ no
4. Have you ever had surgery? □ yes   □ no
5. Have you ever had a head injury? □ yes   □ no
6. Have you ever been knocked unconscious? □ yes   □ no
7. Have you ever passed out during exercise? □ yes   □ no
8. Have you ever been dizzy during exercise? □ yes   □ no
9. Have you ever had a seizure? □ yes   □ no
10. Have you ever had chest pain during or after exercise? □ yes   □ no
11. Have you ever had high blood pressure? □ yes   □ no
12. Have you ever been diagnosed with a heart murmur? □ yes   □ no
13. Do you have diabetes? □ yes   □ no
14. Do you have asthma? □ yes   □ no
15. Have you ever had an eating disorder? □ yes   □ no
16. Have you ever had emotional difficulties for which professional help was sought? □ yes   □ no

Please explain “Yes” answers, noting the number of the questions: ____________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Page 1 of 2   (10/24/19)
Name __________________________

Allergies

Describe reaction and management of the reaction

Medication allergies (list)

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Food allergies (list)

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Other allergies (list)

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Dietary Restrictions

☐ Does not eat pork  ☐ Does not eat eggs  ☐ Does not eat dairy

☐ Other (describe) _____________________________________________

Explain any restriction to activities (e.g. what cannot be done, what adaptation or limitations are necessary)

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Use this space to provide any additional information about participant’s behavior and physical, emotional, or mental health about which camp should be aware:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

To the best of your knowledge, which of the following has the participant had?

☐ Chickenpox  ☐ Measles  ☐ German Measles  ☐ Mumps  ☐ Hepatitis A  ☐ Hepatitis B

☐ Hepatitis C  TB Mantoux Test Result: ☐ Positive  ☐ Negative

Name of family physician: _______________________________________      Phone________________

*(YOU DO NOT NEED A PHYSICIAN’S SIGNATURE)*

Parent/Guardian/Adult Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities as noted.

Signature of custodial parent/guardian or adult camper ____________________________

Printed Name ______________________ Date ____________

If this health history form is for yourself as an adult family member or support person, please complete the section below:

I hereby give permission to Camp Sunshine’s medical personnel to provide emergency treatment and basic first aid for the person herein described. I further understand and consent that I am responsible for all medical expenses.

Signature of adult camper ____________________________

Printed Name ______________________ Date ____________