



# Piedmont Health Services and Sickle Cell Agency



## SUMMER ENRICHMENT CAMP

P. O. Box 20964, Greensboro NC 27420

(336) 274-1507 or 1-800-733-8297

Fax: (336)275-7984

### Camper Application

Application must be completed and signed by a Health Care Provider (Pediatrician, Hematologist, Nurse Practitioner, or Physician Assistant)

*\*PLEASE NOTE: COMPLETED APPLICATIONS ARE APPROVED ON A FIRST COME, FIRST SERVED BASIS. TO ASSURE YOUR RESERVATION, SEND YOUR COMPLETED APPLICATION IN AS SOON AS POSSIBLE.*

PLEASE PRINT OR TYPE APPLICATION

DATE \_\_\_\_\_

NAME: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_ SEX: \_\_\_\_  
*LAST FIRST MIDDLE*

MAILING ADDRESS: \_\_\_\_\_  
*STREET CITY STATE ZIP code*

COUNTY OF RESIDENCE: \_\_\_\_\_ CURRENT GRADE LEVEL: \_\_\_\_\_

PARENT/LEGAL GUARDIAN: \_\_\_\_\_

PHONE: \_\_\_\_\_ WORK: \_\_\_\_\_ EMAIL: \_\_\_\_\_

*PERSON TO BE NOTIFIED IN AN EMERGENCY IF PARENT/GUARDIAN CANNOT BE REACHED:*

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ ALTERNATE PHONE: \_\_\_\_\_

*HEALTH INSURANCE INFORMATION:*

COMPANY \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

TRANSPORTATION TO & FROM CAMP PROVIDED BY \_\_\_\_\_

IF A REQUEST FOR CAR POOLING IS RECEIVED, MAY WE GIVE YOUR NAME & PHONE NUMBER TO OTHERS? \_\_\_\_\_

HAVE YOU ATTENDED SICKLE CELL SUMMER ENRICHMENT CAMP BEFORE? \_\_\_\_\_ WHEN? \_\_\_\_\_

T-SHIRT SIZE (Check one)

- Youth Medium    Youth Large    Adult Small    Adult Medium    Adult Large    Adult X-Large

HOW DID YOU FIND OUT ABOUT SICKLE CELL SUMMER ENRICHMENT CAMP?

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

**Piedmont Health Services and Sickle Cell Agency**  
**SUMMER ENRICHMENT CAMP**  
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***IMPORTANT NOTE: THE NEXT SECTION MUST BE SIGNED BY PARENT OR GUARDIAN.***

**APPLICANT'S NAME** \_\_\_\_\_

**RELEASE OF INFORMATION:** I hereby give permission to Piedmont Health Services and Sickle Cell Agency (PHSSCA) to release or receive information, on the applicant named above, to and from other related professionals and agencies, as necessary for the purpose of serving the client, and with the understanding that such information will be held confidential. I also give permission for PHSSCA to gather information for the purposes of evaluating the camp experience for above named child. Failure to complete this information will have no bearing on my child attending camp.

**CAMP ATTENDANCE RELEASE:** I hereby give permission for the applicant as named above to attend Sickle Cell Summer Enrichment Camp at Camp Carefree.

In consideration for the acceptance of the above named, I/we hereby release any claim or cause of action which may accrue against the PHSSCA and/or Camp Carefree, and any employee or either one and any other person acting with the permission of either, arising out of any injury acquired during his/her stay at the camp, in transit to and from said camp, or during any activity approved by any of said persons. I/we agree to assume any claim which said child in his/her personal capacity might have against any of said persons for injury as herein stated.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PHOTO RELEASE:** I consent to the use and publication by PHSSCA and/or Camp Carefree, its affiliates or others with its consent, of any photographs, negatives, prints, motions pictures, video tapes, pictures on Facebook, or other similar reproductions obtained of the applicant as named above while participating in any camping activity through any medium of communication.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **Piedmont Health Services and Sickle Cell Agency Assumption of Risk and Waiver of Liability Relating to COVID-19**

The novel coronavirus (“COVID-19”) has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people. Piedmont Health Services and Sickle Cell Agency has put in place preventative measures to reduce the spread of COVID-19; however, we cannot guarantee that you or your child(ren) will not become infected with COVID-19. Further, attending the Sickle Cell Summer Enrichment Camp could increase your child(ren)’s or your risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by COVID-19 by attending the Sickle Cell Summer Enrichment Camp and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at the Camp may result from the actions, omissions, or negligence of myself and others, including, but not limited to, staff, counselors, volunteers, and program participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)’s attendance at the Sickle Cell Summer Enrichment Camp or participation in programming (“Claims”). On my behalf, and on behalf of my children, I hereby release, covenant not to sue, discharge, and hold harmless Piedmont Health Services and Sickle Cell Agency and the Board of Directors their current, former, and future agents, representatives, and employees and related entities of and from the Claims, including all liabilities, claims, actions, damages, costs, or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of Piedmont Health Services and Sickle Cell Agency, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any Sickle Cell Summer Enrichment Camp.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Parent/Guardian

\_\_\_\_\_  
Name of Student Participant(s)

**HEALTH HISTORY/EMERGENCY TREATMENT RELEASE**

**To be completed by parent or guardian**

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PLEASE ANSWER ALL QUESTIONS:

Camper Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Hemoglobin Type: \_\_\_\_ SS \_\_\_\_ SC \_\_\_\_ S-Thal \_\_\_\_ Other \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Allergies (i.e., foods, drugs, insect bites, etc.) \_\_\_\_\_

Dietary Restrictions (if any): \_\_\_\_\_

Other Medical Conditions (i.e., asthma, diabetes, seizures, heart conditions, etc.)

Please list any physical restrictions or limitations to an activity (i.e., no contact sports, uses walker, etc.):

**Immunization Record and COVID-19 Vaccination Record-ATTACH COPY**

Date of last hospitalization; please specify reason for admission: \_\_\_\_\_

Please list name of medicine, dose and time schedule:

Medicine	Dosage	Frequency/Time Schedule

**EMERGENCY TREATMENT RELEASE:**

Name of Camper: \_\_\_\_\_

This health history is correct as far as I know, and the above named person has permission to engage in all prescribed camp activities except where noted. I hereby give permission to the camp:

1. To provide ongoing health care
2. To select medical personnel and to order x-rays or routine tests or treatment for the camper.

In the event I cannot be reached in an emergency, I hereby give permission to the appointed medical director or camp physician to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the above named person. This form may be photocopied for use out of camp.

Signature of Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_



**PIEDMONT HEALTH SERVICES AND SICKLE CELL AGENCY**  
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**CAMP HEALTH FORM**

**Note: This form must be completed and signed by a physician prior to admission to camp. Campers must have a physical examination within 6 months prior to the camp session. Attach a copy of latest progress notes and immunization record.**

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age** \_\_\_\_\_ **Sex** \_\_\_\_\_ **DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Mailing Address:** \_\_\_\_\_  
Street City State Zip

**Legal Parent (s)/Guardian:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Blood Pressure** \_\_\_\_\_

**Hemoglobin Type:** SS SC S/Thal Other \_\_\_\_\_ **Baseline Hemoglobin:** \_\_\_\_\_

**Other Health Diagnosis:** \_\_\_\_\_

**Significant Findings on Physical Exam:**

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

**Past Medical History:**

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

**General Appearance:** \_\_\_\_\_

**Recent Crisis:** Yes No **Date:** \_\_\_\_\_ **Type:** \_\_\_\_\_

**Drug and other Allergies (drugs, food, insect stings, other):**

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

**Medical action plan specific to disease or allergy:**

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

**Has the camper tested positive for MRSA or VRE?** Yes No **Date cleared:** \_\_\_\_\_

**Menstrual Period:** Yes No NA (note special problems) \_\_\_\_\_

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

**PHSSCA Summer Enrichment Camp Health Form**  
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Is the child cognitively appropriate for his/her age?     Yes     No    If no, explain approximate level of functioning:

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Describe any additional current medical problems or relevant psychosocial information including any behavior problems that might affect the child's participation in a group and overnight camp setting:

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Does child require special medical treatment or other special assistance during camp experience? (oxygen, assistive devices)

Explain: \_\_\_\_\_

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Please list all medications to be administered during camp:

Name of Drug	Dosage	Frequency

Physician Statement: I have examined \_\_\_\_\_ and find him/her physically able to attend camp. I understand the above medical regimen indicated will be followed while he/she is at camp.

Comments or special instructions:

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Physician's Name (Type or Print) \_\_\_\_\_ Date \_\_\_\_\_

Name of Practice or Hospital Affiliation: \_\_\_\_\_

Physician's Signature \_\_\_\_\_

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

Phone \_\_\_\_\_ Fax \_\_\_\_\_