

January 2017

Dear Parents and Campers,

Ross Point Camp & Conference Center is proud to offer Camp JOURNEY. Camp Journey is a no-cost resident and day camp for children diagnosed with cancer, on or off therapy. We are located in Post Falls, Idaho (18 miles east of Spokane).

You can visit the camp website at [www.rosspoint.org](http://www.rosspoint.org) to see the camp layout. Two applications are enclosed, one for your child and one for a sibling or friend.

**PROGRAMS**

**Day Camp**

**Monday, 31–Thursday, August 3, 2017 (9:15–4:00 pm each day)**

*On-site Registration: Monday, July 31, 8:45 am*

This camp is designed for **5- to 7-year-old** cancer patients and survivors. These campers do not bring a sibling or friend along to camp. Parents are invited to attend on Monday from 8:45–11:30 am. Lodging may be available for families traveling from outside the area (approximately 2 hours away or more). Please call to request lodging.

**Resident Camp**

**Sunday, July 30–Saturday, August 5, 2017**

*On-site Registration: Sunday, July 30, 2:00–3:30 pm*

This camp is designed for 7- to 17-year-old cancer patients and survivors. Campers are invited to bring along one sibling, or a friend of similar age, to share in the camp experience. Airline transportation may be available for campers traveling from outside the area. Please call to request airline transportation.

**Leader-in-Training**

**Sunday, July 30–Saturday, August 5, 2017**

*On-site Registration: Sunday, July 30, 2:00–3:30 pm*

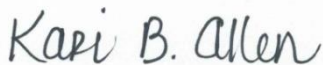
This program is designed for **16- and 17-year-old** cancer patients and survivors who are looking for outstanding leadership training, are interested in developing new skills, and want a chance to see what being a leader is all about. LITs share their talents and enthusiasm with younger campers and create new friendships or rekindle old ones. LITs are invited to bring along one sibling, or a friend of similar age, to share in the camp experience. (**Note:** If **sibling** is not 16 or 17, he or she **can** participate in the resident camp.) Airline transportation may be available for LITs traveling from outside the area. Please call to request airline transportation.

Camp JOURNEY is staffed solely by volunteers, including pediatric oncology professionals from the local area, and offers a variety of exciting programs. Please read through the enclosed brochure for information about programming activities.

After we receive your completed application, we will mail your camper an acceptance packet the week of June 5, 2017. This packet will contain additional paperwork, such as health forms, to be completed and returned by July 10, 2017. The acceptance packet will also include pre-camp information, such as a packing list, directions, and contact numbers.

Don't delay—please submit your initial camp paperwork as soon as you can!

Sincerely,



Kari Allen  
Kari@rosspoint.org  
Camp Director  
509-863-7379



Angela Trobaugh-Lotrario, MD  
Volunteer Camp Medical Director

# Camp JOURNEY

## 2017 Camper Eligibility Guidelines

### Day Camp Eligibility (Ages 5–7)

- A child from eastern Washington, northern Idaho, northeastern Oregon, or western Montana who has been diagnosed with cancer and meets one of the following criteria:
  - ✓ Is on active cancer therapy
  - ✓ Has completed cancer therapy
  - ✓ Has had bone marrow transplantation (BMT) or stem cell transplantation (SCT)

### Resident Camp Eligibility (Ages 7–17)

- A child from eastern Washington, northern Idaho, northeastern Oregon, or western Montana who has been diagnosed with cancer and meets one of the following criteria:
  - ✓ Is on active cancer therapy
  - ✓ Has completed cancer therapy
  - ✓ Has had bone marrow transplantation (BMT) or stem cell transplantation (SCT)
- A sibling\* or friend of a camper described above
 

**\*Note:** A sibling who has attended camp previously and lost his or her sister or brother within the past 2 years may attend camp for one additional year

## Camp JOURNEY 2017 CAMPER APPLICATION

<b>CAMP DATES</b>	
<b>Day Camp</b> (ages 5–7)	July 31–August 3, 2017
<b>Resident Camp</b> (ages 7–17)	July 30–August 5, 2017
<b>Leader-in-Training</b> (ages 16 & 17)	July 30–August 5, 2017

**Please complete and return by May 15, 2017, to:**  
**Camp JOURNEY**  
**PO Box 8717**  
**Spokane, WA 99203**

**Children are accepted based on the outlined Camper Eligibility Guidelines.**

**Child's Full Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
Last First Middle

Gender:  Male  Female      Age: \_\_\_\_\_      Grade in school (2016–2017): \_\_\_\_\_

**Child is:**  On therapy    Off therapy    Post BMT/SCT    Friend    Sibling

**Who is your child coming to camp with? Name:** \_\_\_\_\_

Is this a friend or sibling of your child?  Friend  Sibling

**Parent/Guardian Name:** \_\_\_\_\_

Mailing Address: Street \_\_\_\_\_

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

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_      Email: \_\_\_\_\_

Mother Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_      Father Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Mother Work: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_      Father Work: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Preferred method of contact (e.g., email, home #, cell #): \_\_\_\_\_

**Emergency Contact** *(if parent or guardian cannot be reached)*

Name: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_      Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Relationship to child: \_\_\_\_\_

**T-Shirt Size:** Youth Size   S   M   L   XL   **OR**   Adult Size   S   M   L   XL   XXL   XXXL

**MEDICAL HISTORY** (to be completed by *all children applying*)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Allergies**

Does your child have any food, drug, or other allergies? (please check one)  Yes  No

**If Yes**, please describe allergen (i.e., name of medication, food, environment, animals) and severity of reaction:

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**Immunization History (DATES REQUIRED—provide date of most recent shots)**

Last Tetanus\*: \_\_\_\_\_ Varicella\*\* (chicken pox): \_\_\_\_\_  Disease or  Vaccine  
(must be within the last 10 years) (check one)

*\*If a date of last tetanus shot is not provided, then the camper will receive a tetanus shot if needed.*

*\*\*For the protection of campers on cancer treatment, all patients off therapy, siblings, and friends must have had either chicken pox or the varicella vaccine.*

**Expected Medications**

Medications must be brought in original pharmacy containers. Please be sure to bring enough medication to get your child through the entire week. **Please do not bring medications in medication organizers or bubble packs with multiple medications.**

Medication	Dose/Time	Days of Week

**Bring updated list of medications to camp. Attach additional sheet as needed.**

Is there any special routine when medications are given?  Yes  No

Please describe: \_\_\_\_\_  
\_\_\_\_\_

Are any special foods or fluids given with the medications?  Yes  No

Please describe: \_\_\_\_\_  
\_\_\_\_\_

### Non-Prescription Medications

Camp will provide the non-prescription medications listed below. Please check “Yes” or “No” for each medication; a missing check mark will be assumed to be a “Yes” response.

*I authorize the following medications to be administered under supervision of the Camp Medical Director and/or nurse as needed:*

<b>Tylenol</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Antacid</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Ibuprofen</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Chloraseptic</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Cough drops</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Benadryl</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Cough syrup</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Anti-diarrheal</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Sudafed</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### Past Medical Issues

Please list past major medical issues (other than cancer—e.g., surgeries, broken bones, major illness):

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*If no major medical issues to list, check here:*  None

### Current Health Conditions

Please describe any current health conditions requiring medication, treatment, or special consideration while at camp. *If none to list, check here:*  None

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### Other Medical Conditions

Indicate with “Yes” any of the following conditions exhibited by your child. Please provide detailed information about his or her limitations. Do not hesitate to use an additional sheet to provide additional information that will help us better understand your child.

Yes\_\_\_ No\_\_\_ Visual impairment: \_\_\_\_\_

Yes\_\_\_ No\_\_\_ Hearing impairment: \_\_\_\_\_

Yes\_\_\_ No\_\_\_ Seizures: \_\_\_\_\_

Yes\_\_\_ No\_\_\_ Cognitively (academically) functions below age level: \_\_\_\_\_

Yes\_\_\_ No\_\_\_ Asthma: \_\_\_\_\_

Yes\_\_\_ No\_\_\_ Diabetes: \_\_\_\_\_

Yes\_\_\_ No\_\_\_ Heart defect/disease: \_\_\_\_\_

Yes\_\_\_ No\_\_\_ Bed-wetting: \_\_\_\_\_

Yes\_\_\_ No\_\_\_ Prosthesis: \_\_\_\_\_

Yes\_\_\_ No\_\_\_ Bleeding/clotting disorder: \_\_\_\_\_

Yes\_\_\_ No\_\_\_ Other: \_\_\_\_\_

➤➤ **For Female Campers** <<

Has your child ever menstruated?  Yes  No **If No**, has she been told about it?  Yes  No

**If Yes**, is her menstrual history normal?  Yes  No

**CANCER MEDICAL HISTORY** (to be completed by *patients or former patients only*)

Cancer Diagnosis/Site: \_\_\_\_\_ Current Status:  Active  Remission

Date of Diagnosis: \_\_\_\_\_ Date Treatment Ended: \_\_\_\_\_

History of BMT: \_\_\_\_\_ History of Recurrence: \_\_\_\_\_

Oncologist: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Any other physicians or healthcare providers we should be aware of? \_\_\_\_\_

Special Devices:  Broviac/Hickman  Port  Ostomy  PICC

Care (flushes/dressing): \_\_\_\_\_

**CAMPER INFORMATION—PARENT PORTION**

We would like to get to know a bit about your child before he or she comes to camp. Please answer the following questions as thoroughly as possible. The information will be used for both evaluation of acceptance to camp and camper placement. Information is shared with the camper’s counselors prior to camper arrival to help promote the best camp experience possible. *(Please use additional paper as needed.)*

**Parent Recommendations**

- 1. Any swimming or diving restrictions?  Yes  No *If Yes, please explain:* \_\_\_\_\_  
\_\_\_\_\_
- 2. Any restrictions on activity level?  Yes  No *If Yes, please explain:* \_\_\_\_\_  
\_\_\_\_\_
- 3. Any other restrictions while at camp? \_\_\_\_\_  
\_\_\_\_\_

**Special Activities of Daily Living Needs** *(Indicate with a “Yes” any assistance needed by your child and explain.)*

- Yes  No Dressing: \_\_\_\_\_
- Yes  No Eating: \_\_\_\_\_
- Yes  No Bathrooming: \_\_\_\_\_
- Yes  No Walking from place to place (balance/endurance): \_\_\_\_\_
- Yes  No Needs wheelchair assistance (describe): \_\_\_\_\_

Has your child ever been to camp before?  No  Yes

*If Yes, name of camp and age at which child attended:* \_\_\_\_\_

Is your child having any difficulties now, physically or emotionally?

No  Yes *If Yes, please describe:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe your child’s special qualities (e.g., quiet, active, hobbies, interests): \_\_\_\_\_  
\_\_\_\_\_

Please describe any bedtime or sleep habits of your child and how they are handled at home:

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Camp is filled with many activities (e.g., swimming, canoeing, climbing wall, hiking, high ropes course, sports, crafts). Are there any restrictions on these or other activities?

Yes     No    **If Yes,** please describe: \_\_\_\_\_

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Anything else you would like to tell us about your child that could enhance his or her camp experience?

Yes     No    **If Yes,** please describe: \_\_\_\_\_

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### **CAMPER INFORMATION—CHILD PORTION**

What excites you about coming to Camp JOURNEY? \_\_\_\_\_

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What, if anything, concerns or worries you about coming to camp? \_\_\_\_\_

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### **REQUIRED Parent/Guardian Signature**

*The information given in this application and health history is true and accurate to the best of my knowledge. I give my permission for camp staff to administer listed prescribed medications and authorized non-prescription medications as indicated in this application. I further give my permission to administer other medications as needed and indicated by a physician.*

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_