

Cancer Hope Foundation  
568 Constitution Ave. Units F&G  
Camarillo, CA 93012

Phone: (805) 384-5445  
Fax: (805) 384-2203  
www.cancerhopefoundation.org

## Camp Keepsake

A program of **Cancer Hope Foundation**♥  
GROUP APPLICATION

For the purpose of this application, the applicant is the person with cancer. Please fill in the information as completely as possible. The camping experience is intended for the campers and up to five additional guests. These guests can be members of their family, close friends, or caregivers.

PLEASE RETURN YOUR APPLICATION AS SOON AS POSSIBLE. Space is limited. Please note that submitting an application does not ensure an invitation. All completed applications will be reviewed and considered by our selection committee. Selection of applicants for each camp session is solely within the discretion of the selection committee. Each camp session required a new application. This camp session is primarily geared toward adults who are recently out of treatment or currently undergoing treatment and are still physically able to attend camp. You will be notified as soon as possible as to the status of your application.

ALL INFORMATION IS CONFIDENTIAL.

Applicant Full Name: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

*The following information is needed to help us plan for your Camp adventure:*

Names of All People In Your Group:	Relationship (applicant, spouse, friend, daughter, partner, etc.)	Age	Address	Phone	T-Shirt Size: S,M,L,XL,XXL

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### HEALTH HISTORY

The information below is for the Camp Physician and Nurse Staff and is treated in a confidential manner. It will enable us to plan for your needs. Patients will be responsible for administration of all routine medications and treatments themselves. All medications must be brought with the camper and clearly labeled with the patient's name, drug name, dosage, and times per day taken. Please bring other supplies you may need to camp.

If the applicant needs IV therapy during camp, this can be done with prior arrangement through the Camp Nurse.

Applicant's Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Grade or Stage: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ Treatment Center: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Is there a central venous access device? (Hickman, Grosong, Port-A-Cath) \_\_\_\_\_

If so, what type: \_\_\_\_\_

Is patient independent with care of line? \_\_\_\_\_

How often do you flush line? \_\_\_\_\_

What kind of dressing is used? \_\_\_\_\_

How often is the dressing changed? \_\_\_\_\_

Have there been any recent problems with the line? \_\_\_\_\_

Is applicant under any type of treatment at this time? \_\_\_\_ Yes \_\_\_\_ No

Is treatment active? \_\_\_\_ Maintenance? \_\_\_\_ Post BMT? \_\_\_\_

Date of last chemo: \_\_\_\_\_ What was the therapy? \_\_\_\_\_

Is there a post-chemo symptom control regime? \_\_\_\_\_

When do you expect the next Nadir? \_\_\_\_\_

Are there any concerns we can help you with? \_\_\_\_\_

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

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### GROUP HEALTH HISTORY

The following information is treated in a confidential manner, is for the Camp Physician and Head Nurse and must be completed for every member of your group attending:

Name of <u>each</u> camper who will be attending	Immunized?	Date of Last Tetanus Booster	Had Chicken Pox or Vaccine?	Diabetes?	Allergies Yes/No To what?	Asthma?	Prosthesis?

### MEDICATION PROFILE -OTHER THAN CHEMO

Name of each camper who will be attending	Medication	Indication	Dosage	Route	Frequency

Are there any other medical conditions of campers in your group that we should be aware of? \_\_\_\_\_

IMPORTANT: IF THERE ARE ANY SIGNIFICANT CHANGES TO ANY OF THIS INFORMATION BETWEEN NOW AND CAMP, PLEASE CALL OUR OFFICE.

Please return this completed form to the address listed on the top of each page.