

# CAMP FUNSHINE

A Free Camp for Children with Cystic Fibrosis  
P.O. Box 576 Pea Ridge, AR 72751  
[www.CampFunshine.com](http://www.CampFunshine.com)



## Camper and Peer Counselor Application

Camper Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Sex: Male Female E-Mail: \_\_\_\_\_



Name: \_\_\_\_\_ Relationship  
Last First To Camper: \_\_\_\_\_

Address: \_\_\_\_\_ Camper Mailing Address? Y/N

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Cell/Pager: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship  
Last First To Camper: \_\_\_\_\_

Address: \_\_\_\_\_ Camper Mailing Address? Y/N

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Cell/Pager: \_\_\_\_\_ E-Mail: \_\_\_\_\_



Emergency Contact: \_\_\_\_\_ Relationship  
To Camper: \_\_\_\_\_

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

Authorized to pick up camper if parent Cellular/pager: \_\_\_\_\_  
Or guardian is not available? Y/N

Parent/ Guardian Initials: \_\_\_\_\_



Doctors Name: \_\_\_\_\_ Office Number: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_



Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

CIDCS Number: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_



T-Shirt Size: Child- Small Medium Large  
Adult- Small Medium Large XL XXL

Have you ever been to a Cystic Fibrosis camp before? Y/N  
If no: How did you hear about CF Camp?



Have you ever been away from home before? Y/N  
Can you swim? Y/N Level: Beginner Intermediate Olympian!

List some of your favorite things to do: \_\_\_\_\_

List some of your least favorite things to do: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

All Medical Conditions/Problems:

\_\_\_\_\_

Medications:

\_\_\_\_\_

The ThAIRapy Vest is an alternative airway clearance method and is used in the place of chest physical therapy. Do you have a ThAIRapy Vest? Y/N Would you like to try the ThAIRapy Vest at camp? Y/N

Camp Funshine Attendees **MUST** submit a sputum culture obtained between the dates stated in the opening letter. Parents and campers should discuss attending camp and the results of the sputum culture with their physician. Their physician **DOES NOT** make the determination of whether the child may attend Camp Funshine. That final decision, based on the sputum culture results, is determined by our physician. It is the attendees/parents responsibility to make arrangements with your physician's office to fax or mail a copy of the sputum culture results to the Camp Funshine Director, Jeff Brown.

**THE PHYSICIAN STATEMENT FORM AND/OR CULTURES MUST BE RECEIVED  
NO LATER THAN THE DESIGNATED DEADLINE DATE.**

If there are concerns about the sputum culture, your CF physician may contact the Camp Funshine Director, Jeff Brown, at (417)341-1179 OR (832)541-9276.

**NO PARTICIPANT WITH CF WILL BE ABLE TO ATTEND WITHOUT A  
PHYSICIAN STATEMENT OR SPUTUM CULTURE RESULTS.**

In an effort to provide you with the safest and healthiest camp environment, we have adopted an INFECTION CONTROL PROGRAM which includes: hand washing before every meal; avoidance of handling other persons respiratory equipment, proper disposal of contaminated tissues, etc.

If you have any questions or concerns, you may contact Jeff Brown at (832) 541-9276.

Camper/Counselor Name: \_\_\_\_\_

- 1) I give permission for (myself) my child to attend Camp Funshine
- 2) I give permission for (myself) my child's name and phone number to be distributed in the Camp Funshine Log Book.
- 3) I give the Camp Funshine Physician and medical staff permission to administer any medical needs to the above named camper/counselor while he/she is attending Camp Funshine.
- 4) I give permission for (myself) my child to participate in an off-camp grounds trip under the guidance of responsible adults, if necessary.
- 5) I understand that although every possible precaution is being taken to avoid the passage of viral or bacterial-respiratory illness at camp, there is no way to provide 100% protection to the campers/counselors.

With the INFECTION CONTROL PROGRAM in place at camp, any risk would be minimal, but I understand such transmission of infection could result in a more rapid progression to permanent lung damage or death. Therefore, I agree not to hold Camp Funshine Foundation Inc., the Camp Chaparral Campgrounds, or any camp employee/volunteer legally responsible for damages if such an event were to happen.

In reference to the participation of the above camper in the activities of CAMP FUNSHINE during the week of camp. I (we) grant the following permission to the staff acting under the direction of the designated Camp Director, Physician and Staff.

To perform examinations, administer medications, and/or oxygen, perform emergency surgery, and any other treatments that are deemed advisable by the Camp Physician, as well as admit the camper/counselor to designated hospital for which I (we) assume full financial responsibilities; and to allow the above named camper/counselor to leave the camp for purposes/activities deemed appropriate and advisable by the Camp Physician.

I (we) also understand he/she will be asked to leave Camp Funshine for repeated misconduct and breaking any camp rules or regulations, and that I (we) will be notified to make arrangements to pick up my (our) child if this occurs. Camp Funshine staff must comply with the same rules and regulations, and will be asked to leave for misconduct.

I (we) give consent to have photographs, audio tapes, video tapes, or films made of my (our) child. I (we) understand and agree that these photographs, tapes and/or films may be used by Camp Funshine Foundation, Inc. for education, publicity, advertising, or any other purpose, in the sole discretion of Camp Funshine, Inc. or Camp Funshine without compensation to me (we) of any kind.

I (we) understand that my (our) child's participation in Camp Funshine is voluntary. I (we) also agree that in the event of any injury, or injuries, to my child, from his/her participation in any Camp Funshine activities, I (we) release Camp Funshine foundation, inc., and/ or any persons participating as camp staff, from liability of these injuries. My (our) signature below acknowledges voluntary authorization for my (our) child's participation in any and all activities at Camp Funshine. Both parents signatures if possible.

	Parent/Guardian Signature	Date
Camper/Counselor Signature    Date		
	Parent/Guardian Signature	Date

There is a possibility of cross-infections between individuals with CF, even when they observe proper hygienic measures. Camp Funshine prohibits individuals who culture positive, with either Burkolderia Cepecia Or MSRA, from attending the camp because of risk to others. Because sputum cultures are not 100% accurate, and despite efforts to restrict attendance by those cultures with Burkoldria Cepecia or MSRA, Camp Funshine cannot guarantee a camp free of risk for cross-infection. Decide for yourself if you should attend Camp Funshine.

-- I understand that Camp Funshine Foundation, Inc. (i.e. CFFI) together with its assignees, officers, agents, employees, officials and volunteers have undertaken reasonable precautions to prevent the communication of viral/bacterial respiratory illness or infection. I understand that despite the reasonable precautions undertake by the CFFI, the risk of communication of viral/bacterial respiratory illness or infection cannot be eliminated.

-- I permit my child (or myself) to participate in Camp Funshine knowing this risk of viral/bacterial respiratory illness or infection. I further understand the communication of viral/bacterial respiratory illness or infection could result in a more rapid progression to permanent lung damage or death.

-- I further declare that I have an adequate opportunity to review this medical release form, and an opportunity to inquire about the precautions to prevent the communications of viral/bacterial respiratory illness or infection undertaken by the camp.

-- I agree to not hold CFFI/Camp Funshine, its assignees, officers, agents, employees, officials and volunteer or the Camp Chaparral Campgrounds, legally responsible for damages in the event my child (or my self) contracts a viral/bacterial/fungal respiratory illness or infection at Camp Funshine, or in route to and/or from Camp Funshine.

	Date
Camper Signature	

	Date
Parent/Guardian Signature	

*It is mandatory for the CF individual to return this page and to bring there own medications and equipment.*

**Camper/Counselor Name:** \_\_\_\_\_

Do you have a Port? Y/N If yes, Will it need to be flushed at camp? Y/N

Do you have a G-Button? Y/N If yes, Will you need Milk Drips during camp? Y/N

**SPECIAL DIETARY NEEDS (Diabetic, Milk Drips, Ensure, ect.):**

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**RESPIRATORY MEDICATIONS (Pulmozyme, Albuterol, Tobi, ect.):**

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**CHEST PHYSICAL THERAPY (times per day)    1            2            3            4**

**MEDICAL EQUIPMENT to be brought to camp (Ultra-Neb 99, Pulmo-Aide, Flutter, ect.):**

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**ENZYMES (Pancreas, Creon, Ultase, ect.):**

Dose with meals: \_\_\_\_\_

Dose with snacks: \_\_\_\_\_

**OTHER MEDICATIONS:**

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**ALLERGIES (To Food, Medications, ect.):**

Please complete this schedule and return it with your Application Packet. Make sure to list all Oral Medications, supplements, vitamins, ect., used by the CF participant each day. Use additional paper if necessary. Thank you!

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

Date of Birth: \_\_\_\_\_

Cabin Number: \_\_\_\_\_

<b>Time of Day</b>	<b>Daily Medications</b> (Describe normal routine)	<b>Special Medications</b> (Please note day & time)	<b>Aerosol Medications</b> ie. Albuterol, Tobi, Pulmozyme, ect <b>Chest PT &amp; Times</b>
Morning  Breakfast			
Mid-morning  Lunch			
Afternoon  Dinner			
Evening  Bedtime			





*PLEASE DETACH AND RETURN THIS PAGE SEPARATELY!*

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

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

I certify that \_\_\_\_\_ based on all sputum

Patient Name

Cultures, obtained in the last year, and performed at a designated CF CENTER LABORATORY, has not been shown to hold Burkholderia Cepacia or Staphylococcus, which is resistant to methicillin (MRSA).

I have discussed with \_\_\_\_\_ (or parents, if

Patient Name

under the age of 18) the risks of cross-infection from casual contacts between individuals with cystic fibrosis.

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PLEASE FAX, MAIL, or EMAIL TO:

Camp Funshine  
Attn: Jeff Brown  
1157 Flint Ln.  
Washburn, MO. 65772  
(832) 541-9276 FunshineEmail@aol.com

Fax# (417) 341-1179

-Please call before faxing, as the fax & phone share the same line-

**THIS FORM MUST BE RECEIVED BY JEFF BROWN, ALONG WITH CULTURE(S) AS SOON AS POSSIBLE. (Deadline is in enclosed letter.)**

Date: \_\_\_\_\_

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

Physician's Printed Name: \_\_\_\_\_

Physician's Office Phone: \_\_\_\_\_

Physician's Fax Number: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

I Authorize \_\_\_\_\_ to release the last four sputum culture results, to Camp Funshine Director, Jeff Brown and the Camp Doctor.

This is ONLY NEEDED IF your Dr. will not sign the Physician Statement. In that case, we need a minimum of 4 test results. A mandatory culture, obtained between the dates in the enclosed letter, is included in this total four. Please contact Jeff Brown at (832) 541-9276 if you have questions.

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PLEASE FAX, MAIL, OR EMAIL TO:

Camp Funshine  
 Attn: Jeff Brown  
 1157 Flint Ln.  
 Washburn, MO. 65772  
 (832) 541-9276 FunshineEmail@aol.com

Fax# (417) 341-1179

-Please call before faxing, as the fax & phone share the same line-

**THIS FORM MUST BE RECEIVED BY JEFF BROWN, ALONG WITH CULTURE(S)  
 REPORT AS SOON AS POSSIBLE. (Deadline is in enclosed letter.)**

Date: \_\_\_\_\_

Patient/Parent signature: \_\_\_\_\_

Office Staff/Physician Name: \_\_\_\_\_

Physician's Office Phone: \_\_\_\_\_

Physician's Fax Number: \_\_\_\_\_