



**Sickle Cell Association of Texas Marc Thomas Foundation**  
 (Headquarters) 314 E. Highland Mall Boulevard, Suite 411, Austin, Texas 78752  
 Office: (512) 458-9767 Fax: (512) 458-9714 Email: info@sicklecelltexas.org  
 Serving Central Texas, San Antonio and Houston  
[www.sicklecelltexas.org](http://www.sicklecelltexas.org)

**SUMMER CAMP APPLICATION FORM**

**\*\*\*\*\* A PARENT/GUARDIAN MUST COMPLETE THIS FORM \*\*\*\*\***

**CAMPER INFORMATION**

**Camper's Name** Last: \_\_\_\_\_ First: \_\_\_\_\_ Nickname: \_\_\_\_\_

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

**Email Address:** (needed for updates) \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **Age at Camp:** \_\_\_\_ **Boy or Girl** \_\_\_\_\_

**Name of School** \_\_\_\_\_ **Last School Grade:** \_\_\_\_\_

**T-SHIRT SIZE**(circle one):

child S (6-7)    child M (8-10)    Adult S (34-36)    Adult M (38-40)    Adult L (42-44)    Adult XL (46-48)

**PARENT/GUARDIAN INFORMATION**

**Parent 1**

**Name Last:** \_\_\_\_\_ **First:** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Address (if different):** \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Parent 2**

**Name: Last:** \_\_\_\_\_ **First:** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Address (if different):** \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**EMERGENCY CONTACTS** (if parents cannot be contacted):

**Name Last:** \_\_\_\_\_ **First:** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

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

**NameLast:** \_\_\_\_\_ **First:** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

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

**CHILD'S PHYSICIAN AND/OR CLINIC:**

**Name of Physician:** \_\_\_\_\_ **Clinic:** \_\_\_\_\_

**Physician's Telephone Number:** \_\_\_\_\_

**CHILD'S MEDICAL INSURANCE INFORMATION:**

What type of medical insurance does your child have? (circle all that apply). \* Please include a copy of your Medicaid or insurance card if applicable.

Medicaid Private Insurance \_\_\_\_\_ None Member/Policy/Group ID Number: \_\_\_\_\_  
 (Please Name Insurance Carrier)



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**CAMPER HISTORY FORM**

\*\*\*\*\* **TO BE COMPLETED BY PARENT/GUARDIAN** \*\*\*\*\*

**CAMPER NAME:** \_\_\_\_\_ **DOB:** \_\_\_/\_\_\_/\_\_\_

**Does your child have Sickle Cell Disease?** (Circle one) Yes No

**Can your child participate in swimming?** (Circle one) Yes No

**Does your child have tubes in his/her ears?** (Circle one) Yes No

**Are immunizations up-to-date including pneumo- and meningococcal vaccine?** Yes No

**Does your child regularly use oxygen, breathing machine, or any machines?** Yes No

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

**Does your child have (or ever had) any of the following medical conditions?** (circle all that apply)

- |                      |                       |                 |                               |
|----------------------|-----------------------|-----------------|-------------------------------|
| Kidney problems      | Breathing problems    | Stroke          | Immune problems               |
| Monthly transfusions | Abnormal TCD          | Asthma          | 2 or more admissions per year |
| Bed wetting          | Allergy Shots         | Pregnancy       | ADD or hyperactivity          |
| Speech problems      | Hearing problems      | Vision problems | Hormone problems              |
| Headaches            | Skin/Staph Infections |                 |                               |

If any of the above conditions is present, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Is your child allergic to anything?** (Medication, foods, insects, etc) \_\_\_ Yes \_\_\_ No

If yes, please list the allergy and reaction:

Allergy	Reaction
_____	_____
_____	_____
_____	_____

**Parent Name (Please Print):** \_\_\_\_\_

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



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**MEDICATION RELEASE**

\*\*\*\*\* **TO BE COMPLETED BY PARENT/GUARDIAN** \*\*\*\*\*

**CAMPER NAME:** \_\_\_\_\_ **DOB:** \_\_\_/\_\_\_/\_\_\_

**Over the Counter Medication:** The following are medications that we keep on hand at camp. Please place a check by all of the medications that you are comfortable with us giving your child. All medications are given according to instructions found on the medication and per Camp Physicians' Protocol.

- |                           |                                |                                  |
|---------------------------|--------------------------------|----------------------------------|
| Acetaminophen (Tylenol)   | Antihistamine/Allergy Medicine | Aloe                             |
| Ibuprofen (Advil, Motrin) | Robitussin or equivalent       | Calamine Lotion                  |
| Sudafed PE                | Robitussin DM or equivalent    | Antibiotic Cream                 |
| Benadryl                  | Generic Cough Drops            | Lice Shampoo or Cream            |
| Benadryl Cream            | Tums                           | Swimmer's Ear Drops              |
| Sore Throat Spray         | Laxatives for constipation     | Eye Drops (Visine or equivalent) |

**LIST ALL PRESCRIPTION MEDICATIONS AND OVER THE COUNTER MEDICATIONS TAKEN REGULARLY BY YOUR CHILD**

(Including vitamins, birth control pills and over the counter medications that your child will take during camp.)

Name of Medicine	Dose (how many Tablets, spoonfuls, TBS, TSP or ML)	Frequency (How many times a day)	Bringing to Camp?	Times Given (morning, afternoon, night)

**Parent Name (Please Print):** \_\_\_\_\_

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





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## **CAMP CELL-A-BRATION ZERO-TOLERANCE POLICY AND AGREEMENT**

The following will **NOT** be tolerated by:

- ⇒ Rough Housing
- ⇒ Disrespecting staff, counselors, camp staff and other campers (**this also applies to parents of campers**)
- ⇒ Not following directions, not listening, bullying other campers and staff
- ⇒ Profanity abuse or threatening language or behavior
- ⇒ Gang related clothing or paraphernalia
- ⇒ Physical contact, fighting, assault and/or violence
- ⇒ Taking or touching other’s property without permission
- ⇒ Separating from the group
- ⇒ Drugs or alcohol
- ⇒ Weapons or firearms
- ⇒ Violation of curfew

Camp Cell-A-Bratation adheres to a strict Zero Tolerance Policy. Parents will be called immediately upon any infraction of the above listed camp guidelines. I understand that if I cannot be reached, the emergency contact listed on the camper’s application will be notified.

I, \_\_\_\_\_, understand that I, the parent, will be responsible for any items that my child (camper), \_\_\_\_\_, breaks or damages while at Camp Cell-A-Bratation/Camp For All. I understand that if my child experiences a disciplinary problem (breaches the Zero Tolerance Agreement), he/she will be removed from their cabin and placed under strict supervision. Upon 2<sup>nd</sup> infraction, he/she will not be able to attend any of the regularly scheduled camp activities. If the child continues to cause problems and violates the Camp Guidelines, the child must be **picked up by a parent** or guardian and will not be able to participate in the following year’s Camp Cell-A-Bratation. I also understand that my child may be immediately dismissed from Camp for a violation of the Zero Tolerance policy if the Camp Director deems it necessary.

\_\_\_\_\_  
 (Initial here) **ADDITIONALLY, I UNDERSTAND THAT COMPLETING THIS APPLICATION DOES NOT NECESSARILY MEAN MY CHILD WILL BE ACCEPTED INTO CAMP. FACTORS INLCUDING FUNDING, PAST BEHAVIORS, CERTAIN CIRCUMSTANCES AND/OR SPACE WILL DETERMINE IF MY CHILD WILL BE ACCEPTED.**

I acknowledge and understand this agreement between the Sickle Cell Association of Texas Marc Thomas Foundation, my child, and myself. I have also been given a copy of this agreement and was offered the opportunity to discuss the above information.

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

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



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**CAMP CELL-A-BRATION  
PHOTOGRAPHY/VIDEO RELEASE FORM**

I, \_\_\_\_\_ give permission for the Sickle Cell Association of Texas Marc Thomas Foundation (SCAMTF) to take and use any photographs/videos of \_\_\_\_\_, including the use of his/her name, for general promotional purposes now or in the future in keeping with the general goals of the Association.

I agree that photographs and/or videos taken of \_\_\_\_\_, including transparencies, negatives, prints, electronic versions and products thereof, may be used by the SCAMTF in a legitimate manner for educational program development and/or promotion including but not limited to fundraising, website usage, brochures, pamphlets, flyers, presentations, outreach, advocacy, education, sponsorship information, media and literature. By signing this document, I agree that I am granting the SCAMTF the right to exhibit the photo/video images for the aforementioned purposes.

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

\_\_\_\_\_  
Relationship of persons signing Document

\_\_\_\_\_  
Date



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## **CAMP CELL-A-BRATION CAMPER GENERAL LIABILITY RELEASE, WAIVER, INDEMNIFICATION AND AGREEMENT NOT TO SUE**

- 1. PARTICIPATION CONSENT:** I, the undersigned parent/legal guardian of \_\_\_\_\_, authorize said child's participation in CAMP CELL-A-BRATION("CAMP"), including all related activities. I fully understand all of the dangers, hazards and risk that are associated with and may occur as a result of my child's participation in the CAMP and related activities. These activities include, but are not limited to, the activities of horseback riding, high and low elements ropes course, swimming, archery, riflery, sporting activities, canoeing, and other camp related activities. I understand that these activities are voluntary and I have familiarized myself with Camp Cell-A-Bration Program and activities at Camp For All in which my child will be participating. I understand that these dangers and risks may result in property damage and/or loss, impairment to health and well-being, and/or physical injury, including serious or even fatal injuries. I acknowledge that although Camp Cell-A-Bration and Camp For All have taken safety measures to minimize the risk of injury to camp participants, Camp Cell-A-Bration and Camp For All cannot insure or guarantee that the participants, equipment, premises or activities will be free of hazards, accidents or injuries. I recognize and have instructed my child in the importance of knowing and abiding by the rules, regulations, and procedures for Camp Cell-A-Bration at Camp For All. I also agree to inform Camp Cell-A-Bration of any activities in which my child may not participate.
- 2. EXCULPATORY AND INDEMNITY CLAUSE.** In consideration of my child being permitted to participate in the CAMP (free of charge), I agree to assume full responsibility for all risks. **I further agree to release, waive, agree to hold harmless and covenant not to sue the Camp Cell-A-Bration,** and all purposes the Sickle Cell Association of Texas Marc Thomas Foundation a non-profit agency, and its board of directors, officers, agents, employees, volunteers, and Camp For All (referred to collectively as "Releasees"), from and against any and all liability, claims, demands, actions, causes of action, suits in equity, whatsoever arising out of or related to any loss, damage, loss of property, or injury, including fatal injuries along with court costs and attorney's fees and expenses whether caused as a result of sole, joint or concurrent negligence, negligence per se, statutory fault or strict liability of releases or otherwise, that may be sustained by my child while participating in CAMP and CAMP related activities while in or upon the premises where the CAMP and related activities are being conducted or while being transported to, from or in connection with the CAMP. I understand this waiver does not apply to injuries caused by intentional or grossly negligent conduct. I further agree to indemnify the Releasees from liability, claims, demands, actions, causes of action, or suits in equity arising out of loss, damage or injury that occurs as a result of my child's negligent or intentional act or omission while participating in the CAMP and in related activities.
- 3. NO INSURANCE.** I understand that Releasees may or may not maintain any insurance policy covering any circumstance arising from my child's participation in CAMP or any event related to that participation. As such, I am aware that I should review my personal insurance coverage. CAMP and SCAMTF may not carry general liability insurance to cover claims arising from CAMP and CAMP activities so it seeks a waiver of claims as additional consideration for the right to participate so CAMP and the SCAMTF, can (a) provide the CAMP free of cost to most participants; and (b) to provide access to a greater number of participants by expending limited resources on program materials and activities rather than on liability insurance.
- 4. MEDICAL AUTHORIZATION, INDEMNITY FOR MEDICAL EXPENSES, and WAIVER.** I understand Releasees cannot be expected to control all of the risks articulated in this form and Releasees need to respond to accidents and potential emergency situations. Therefore, I hereby give my consent for any medical treatment that may be required, as determined by a medical professional at an off-site medical facility or hospital, during my child's participation in this activity with the understanding that the cost of any such treatment **will be my responsibility**. I agree to indemnify and hold harmless Releasees



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for any costs incurred to treat my child, even if Releasees has signed hospital documentation promising to pay for the treatment due to my inability to sign the documentation. I further agree to release, waive, discharge, covenant not to sue, and agree to hold harmless for any and all purposes, Releasees from any and all liabilities, claims, demands, injuries (including fatal injuries), or damages, including court costs and attorney's fees and expenses, that may be sustained by my child while receiving medical care or in deciding to seek medical care, including while traveling to and from a medical care facility, **including injuries sustained as a result of sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of Releasees.** I understand this waiver does not apply to injuries caused by intentional or grossly negligent conduct.

5. **BINDS HEIRS.** It is my express intent that this Release, Waiver, Indemnification and Agreement not to Sue shall bind myself, my child, the other members of my family and spouse, if I am living, and my estate, family, heirs, administrators, personal representatives, or assigns, if I am not living.
6. **AGREEMENT OF RELEASE AND VOLUNTARY SIGNATURE:** In signing this Release, Waiver, Indemnification and Agreement not to Sue, **I acknowledge and represent that I have carefully read the document and understand its contents** and that I sign voluntary as my own free act and deed. CAMP and Releasees has not made and I have not relied on any oral representations, statements, or inducements apart from the terms contained in this agreement. I further state that I am at least eighteen (18) years of age and fully competent to sign; and that I have executed this Release for full, adequate, and complete consideration fully intending to be bound by the same.

**PLEASE READ CAREFULLY BEFORE SIGNING.**

By signing below you agree to the terms of the Waiver, Indemnification and Agreement not to Sue and agree to follow all instructions and procedures in order to maintain safety while attending Camp Cell-A-Bration.

Print Camper's Name: \_\_\_\_\_

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





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**PHYSICIAN HISTORY & PHYSICAL EXAM FORM**

\*\*\*\*\* **A PHYSICIAN MUST COMPLETE THIS FORM** \*\*\*\*\*

**CAMPER NAME** (Last, First): \_\_\_\_\_ **DOB:** \_\_\_/\_\_\_/\_\_\_

**Allergies:** \_\_\_\_\_

**SICKLE CELL DISEASE [SCD] TYPE:**

SCD-SS                       SCD-S Beta<sup>+</sup>                       SCD-SC                       SCD-S Beta<sup>0</sup>  
 Sickle cell-other variant: please specify: \_\_\_\_\_

**IMMUNIZATIONS UP TO DATE? Y N**

**PAST MEDICAL HISTORY (Circle all that apply)**

Bacteremia	Stroke	Avascular Necrosis	Acute Chest Syndrome	Splenectomy	Chronic Pain
Meningitis	Abnormal TCD	Asthma	Enuresis	Obstructive Sleep Apnea	> 2 admissions/yr
Ear Tubes	Allergic Rhinitis	Eczema	Priapism	Constipation	Gallstones

Surgeries: \_\_\_\_\_

Last Hospitalization: \_\_\_\_\_

**Chronic transfusion therapy?** Y N                      **Why?** \_\_\_\_\_

Date of last transfusion: \_\_\_\_\_

**Does patient need oxygen, BIPAP, etc at night ?** Y N

Amount/Settings: \_\_\_\_\_

**Pneumovax 23** Date: \_\_\_\_\_ **Meningococcal vaccine** Date: \_\_\_\_\_

**LABORATORY AND RADIOLOGY DATA:**

Baseline Hemoglobin		Baseline Retic	
Last Hemoglobin (Date: _____)		EEG	
Chest X-Ray	Cardiomegaly? Y N	EKG	
Baseline Spleen Size	CM		
TCD Date:	Results	Normal	Conditional Abnormal Not Applicable

**Physician Name (Please Print):** \_\_\_\_\_

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



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**PHYSICIAN HISTORY & PHYSICAL EXAM FORM (Part II)**

**\*\*\*\*\* A PHYSICIAN MUST COMPLETE THIS FORM \*\*\*\*\***

MEDICATIONS	Dose	Route	Frequency	Indication

**PHYSICAL EXAM**      Date: \_\_\_\_\_  
 HT \_\_\_\_\_ cm WT \_\_\_\_\_ Kg HR \_\_\_\_\_ RR \_\_\_\_\_ B/P \_\_\_\_\_ Sats \_\_\_\_\_

	Normal	Abnormal	Comments
<b>General Appearance</b>			
<b>HEENT</b>			
<b>Cardiovascular</b>			
<b>Lungs</b>			
<b>Liver / Spleen</b>			
<b>CNS</b>			
<b>Skin</b>			
<b>Musculoskeletal</b>			

**Physician Signature:** \_\_\_\_\_  
**Printed Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_

**Or Physician Stamp:**

Camper Name (Last, First): \_\_\_\_\_