DAY CAMPER APPLICATION

Ventilation Assisted Child's Name: ______________________________________

Nickname: __________ Birthdate: ___/___/___ Male__ Female __ **T-shirt size**____

<u>Each camper MUST be accompanied at all times by a designated experienced caretaker (a parent, other adult family member, or nurse)</u>. The above named child's designated caretaker will be:

___________________________________ __________________ _______________

NAME (Please Print) RELATIONSHIP T-Shirt Size

Other family members who will be coming to camp are:

Name	Nickname (if any)	Relationship	Age	T-Shirt size
_____________________	_________	____________	____	_______
_____________________	_________	____________	____	_______
_____________________	_________	____________	____	_______
_____________________	_________	____________	____	_______
_____________________	_________	____________	____	_______
_____________________	_________	____________	____	_______
_____________________	_________	____________	____	_______

VENTILATION ASSISTED CHILD'S INFORMATION

Diagnosis: ____
Oxygen ____ Amount (liters per minute) _____ hours per day _____
Tracheostomy Dependent ____ Ventilator Dependent ___ Weight: ____________
Allergies: ___________

PHYSICIANS:

Name ________________________________Specialty ________________
Street ________________________________Phone ____________________
City __________________________________State _______ Zip ________

Name ________________________________ Specialty ________________
Street ________________________________ Phone ____________________
City __________________________________ State _______ Zip ________

Special diet (if any): ____

Walks alone ___ Needs assistance ___ Wheelchair ___ Electric ___ Manual ____
Paraplegic ___ Quadriplegic ___

Verbal communication: Yes __ No ___ If NO, please explain how your child communicates: ____
Education: Homebased ___ School setting ___ both ___ Current grade level: ______

Interests, Hobbies, Recreation: ____
____
____

TRANSPORTATION: Families must provide their own transportation to and from camp and may be asked to provide their own field trip transportation if buses are filled.

We heard about VACC Camp from: ____

HOW DO YOU THINK YOUR VENTILATION ASSISTED CHILD AND YOUR FAMILY WILL BENEFIT FROM COMING TO CAMP: ____
____
____
____
____
____
____

HOLD HARMLESS AGREEMENT: I, the parent of the minor child(ren) named in this application, together with my heirs and legal representatives, release and discharge Nicklaus Children's Hospital, its heirs and legal representatives, of and from any and all claims, demands, rights and causes of action of whatever kind and nature, arising from, and by reason of, any and all known and unknown, foreseen and unforeseen causes of action that may be sustained by me or my child(ren) as a consequence of our attendance at the Dr. Moises Simpser VACC Camp. I agree to indemnify Nicklaus Children's Hospital against loss from any and all further claims, demands and actions at law or in equity that may hereafter at any time be made or brought by me or anyone on my behalf for the purpose of enforcing a further claim for damages on account of my and my child(ren)'s attendance at the Dr. Moises Simpser VACC Camp.

CONSENT FOR PHOTOGRAPHY: I, the parent of the minor child(ren) named in this application, hereby grant full permission to Nicklaus Children's Hospital to prepare, use, reproduce, publish and exhibit my and my minor child(ren)'s names, pictures, portraits, likenesses, or voices, or any or all of the above, in connection with VACC Camp in any manner deemed necessary by Nicklaus Children's Hospital. I hereby waive all rights of privacy or compensation which I may have in connection with the use of my and my minor child(ren)'s names, pictures, portraits, likenesses, voices, or any or all of the above in connection with the Dr. Moises Simpser VACC Camp and any use to which the same may be put, applied or adapted by Nicklaus Children's Hospital.

I UNDERSTAND THAT CAMPERS ARE SELECTED BASED ON THEIR ABILITY TO INTERACT WITH OTHERS AND TO BENEFIT MATERIALLY FROM SOCIAL OPPORTUNITIES OFFERED BY THIS PROGRAM. I UNDERSTAND THAT OUR APPLICATION WILL BE SCREENED TO VERIFY OUR ELIGIBILITY TO ATTEND VACC CAMP. I GIVE MY CONSENT FOR CAMP STAFF TO DISCUSS MY VENTILATION ASSISTED CHILD'S MEDICAL AND DEVELOPMENTAL STATUS WITH THE PHYSICIAN(S) NAMED IN THIS APPLICATION.

Home Address: ____
____ **Phone:** ______________

EMAIL ADDRESS: ____________________________ **(very important that we have your email address as that is how we communicate with everyone)**

______________________________ ________________ ___/___/___
Signature of Parent or Guardian Relationship Date
Daytime Phone: ______________

______________________________ ________________ ___/___/___
Signature of Parent or Guardian Relationship Date
Daytime Phone: ______________

Please include a recent full-length photograph of your child, and photos of every person attending camp with you.