Nicklaus Children's Hospital | Dr. Moises Simpser VACC CAMP

* * * **SLEEPOVER CAMPER APPLICATION** * * *

(Please Print Clearly)

PERSONAL INFORMATION

NAME OF VENTILATION ASSISTED CHILD _____

D.O.B.____/____/____ Age _____ approx. Weight _____T-Shirt Size _____

LIST ALL OTHER MEMBERS OF THE IMMEDIATE FAMILY:

Name	Relationship	Age	Coming to Camp?	T-Shirt size
_____	_____	____	Yes ☐ No ☐	_____
_____	_____	____	Yes ☐ No ☐	_____
_____	_____	____	Yes ☐ No ☐	_____
_____	_____	____	Yes ☐ No ☐	_____
_____	_____	____	Yes ☐ No ☐	_____
_____	_____	____	Yes ☐ No ☐	_____

FAMILY'S HOME ADDRESS:

Street _____

City _____ State _____ Zip _____

Phone (_____) _____

EMAIL ADDRESS: _____ (PRIMARY MEANS OF COMUNICATION)

Parents' Daytime Phone Numbers (cell phones):

Mom - (____) _____ Dad - (____) _____

Campers are required to bring two individuals who are capable of assisting the camper throughout the term of the camp. Names of 2 individuals who will be assisting camper and relationship to camper:

1) _____ **2)** _____

VENTILATION ASSISTED CHILD'S MEDICAL INFORMATION

Primary Diagnosis: _____

Secondary/Other Diagnoses: _____

_____

VENTILATOR DEPENDENT? YES☐ NO☐ If yes:

When did child become ventilator dependent? _____

Hours per day on ventilator: _____

Type of ventilator (Brand Name and Model): _____

Current ventilator settings (**please fill out completely**):

Mode_____ Respiratory rate: _____ Sensitivity: _____

Peep: _____ High alarm _____ Low alarm _____ Volume _____ or Pressure _____

Frequency of circuit changes: _____

Company/therapist servicing ventilator: _____

_____

Address: _____

_____ Phone (_____) _____

TRACHEOSTOMY? YES☐ NO☐

If yes:

Type/size: _____

Suctioning frequency: _____

Changing frequency: _____

Please make sure to bring a backup tracheostomy to camp as well as a smaller size tracheostomy for ER purposes

OXYGEN? YES☐ NO☐

If yes: System currently used: Liquid _____ Gas _____ Concentrator _____

Amount: _____liters per minute Hours per day: _____

ALLERGIES: _____

MEDICATIONS (PLEASE NOTE THAT PARENTS ARE RESPONSIBLE FOR ADMINISTERING THEIR CHILD'S MEDICATIONS DURING THE DAYTIME AND AT NIGHT):

Type	Dose/Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

RESPIRATORY TREATMENTS (IF ANY):

Type	Dose/Frequency
_____	_____
_____	_____

FEEDING:

Feeds Orally? Yes ☐ No ☐

If yes: Table food ☐ Soft food ☐ Pureed ☐

Gastrostomy? Yes ☐ No ☐ if yes:

Type/size: _____

Formula (brand and flavor)/diet: _____

Amount and frequency of feedings:

Bolus (amount and frequency): _____ or Continuous (ml/hr): _____

ELIMINATION:

Bowel/bladder control? Yes ☐ No ☐

Requires urine catheterization? Yes ☐ No ☐

If yes: Frequency: _____ Type/size: _____

CHILD'S PRIMARY PHYSICIAN:

Name _____ Specialty _____

Street _____ Phone (_____) _____ Fax (_____) _____

City _____ State _____ Zip _____

OTHER PHYSICIANS, NURSES OR RESPIRATORY THERAPISTS INVOLVED IN CHILD'S CARE (PLEASE INCLUDE CHILD'S PULMONOLOGIST**):**

Name _____ Specialty _____

Agency _____

Street _____ Phone (_____) _____ Fax (_____) _____

City _____ State _____ Zip _____

Name _____ Specialty _____

Agency _____

Street _____ Phone (_____) _____ Fax (_____) _____

City _____ State _____ Zip _____

Name _____ Specialty _____

Agency _____

Street _____ Phone (_____) _____ Fax (_____) _____

City _____ State _____ Zip _____

VENTILATION ASSISTED CHILD'S MOBILITY

Walks alone ☐ Needs assistance ☐

If needs assistance: Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐

If needs wheelchair: Manual ☐ Electric ☐

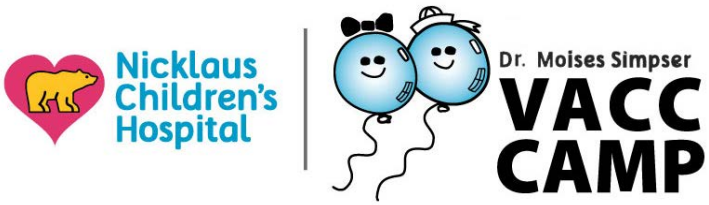
Position in wheelchair: Upright ☐ Reclined ☐

Paraplegic? ☐ Quadriplegic? ☐

Comment: _____

_____

_____



VENTILATION ASSISTED CHILD'S VERBAL COMMUNICATION Yes ☐ No ☐

If child does not communicate verbally, please explain in what manner child communicates

Comment: _____

_____

_____

VENTILATION ASSISTED CHILD'S EDUCATIONAL EXPERIENCE

Homebased ☐ School setting ☐ both ☐

Indicate current grade level and/or comment on type of classroom setting:

_____

_____

IS CHILD RECEIVING PHYSICAL, OCCUPATIONAL OR OTHER SPECIAL THERAPY? If yes,

Type of therapy:

_____

Agency _____ Phone (____) _____

Contact person

_____

Address

_____

City _____ State _____ Zip _____

(IF RECEIVING OTHER THERAPY, DESCRIBE AS ABOVE USING OTHER SIDE OF THIS PAGE.)

HAS CHILD EVER BEEN AWAY FROM HOME/HOSPITAL OVERNIGHT? Yes ☐ No ☐

If yes, explain occasion:

_____

_____

DESCRIBE CHILD'S RECREATION ACTIVITIES AND PERSONAL INTERESTS:

_____

_____

ADDITIONAL INFORMATION WE SHOULD KNOW ABOUT TO MAKE YOUR CHILD'S STAY AT CAMP MORE ENJOYABLE:

_____

_____

DOES ANY OTHER FAMILY MEMBER COMING TO CAMP HAVE SPECIAL NEEDS THAT WE SHOULD BE AWARE OF? IF YES, EXPLAIN:

_____

_____

_____

HOW DO YOU THINK YOUR VENTILATION ASSISTED CHILD AND YOUR FAMILY WOULD BENEFIT FROM THIS PROGRAM:

_____

_____

_____

IMPORTANT - IF YOU FAMILY IS INVITED TO PARTICIPATE:

WILL YOU TRAVEL TO OUR FIELD TRIPS IN OUR BUSES YES☐ NO☐

WILL YOU DRIVE YOUR OWN VEHICLE YES☐ NO☐

ATTACH A RECENT FULL-LENGTH PHOTOGRAPH OF YOUR VENTILATION ASSISTED CHILD.

We also require photos of each member of the family and/or caretaker attending for our ID badges.

I have provided the above information on behalf of my family and declare it to be accurate to the best of my knowledge. I hereby authorize any and all physicians, nurses, therapists and/or educators named in this application to discuss my ventilation assisted child's medical and developmental progress with VACC staff members for purposes of determining my child's capacity to participate in and benefit from the VACC Camp program. I understand that these contacts also serve to help plan camp activities to enhance my child's enjoyment of the program.

_____ _____

Signature of Parent/Guardian Signature of Parent/Guardian

Date: _____/_____/_____ Date: _____/_____/_____

You can fax the application to 786-268-1765 and email the photos

You can scan and email the application and the photos to

bela.florentin@nicklaushealth.org

(Preferred method)

You can return completed application and photograph by mail to:

DR MOISES SIMPSER VACC CAMP
Nicklaus Children's Hospital
3200 S.W. 60th Court, Suite 203
Miami, FL 33155
(305) 662-8222 or 662-8380 Fax 786-268-1765