Camper's Name ________________________________

CAMP OKAWEHNA

TRANSPLANT CAMPER INFORMATION FORM

After completing this form, print it before exiting the screen.
Your information will not be saved when you exit the screen.

Camp Okawehna Processing Depa
Attn: Glenda Streicher
Fax # (615) 341-8814

Date ________________

Information to be Completed by Parent or Legal Guardian and Verified by Health Care Provider
All legal documents must be witnessed/have signature witnessed before acceptance. *Please indicate if no Social Security number is available.

Name (First, Last, MI) ________________________________

Birthdate ________________ *SSN ____________ Sex ☐ M ☐ F

Street Address ________________________________

City ________________ State ____________ Zip ________

Include in Address Book? ☐ Y ☐ N

Home Phone ________________

T-shirt Size ☐ S ☐ M ☐ L ☐ XL ☐ XXL ☐ Child ☐ Adult

Camper Type ☐ Transplant Height ____________ ☐cm ☐ft/inches
☐ Other ________ Weight ____________ ☐kg ☐lbs

Please Check All That Apply:

☐History of Seizures? Date of Last Seizure ________ How Treated ________________

☐History of Heart Disease? ☐On Medication Describe ________________

☐Problems Breathing? ☐Inhaler ____________ ☐Sp. Equipment ____________

☐Learning Disabilities? ☐Unable to Read ☐Language Barrier

☐Social/Behavioral Issues? ☐Overnight Stay w/o Parent/Family ☐Medication (List on Medication Form)

☐Hearing Problems? ☐Hearing Aid ☐Left ☐Right ☐Reads Lips ☐Sign Language

☐Vision Impairment? ☐Glasses ☐Contacts

Primary Language ________________

Physical Limitations

Describe ________________________________
____
____

☐Growth Hormone ☐Walk ½ Mile?

☐Can Walk Up Hills? ☐Uses Crutches?

☐Uses Wheelchair?

☐Can Take Own Meds? ☐Assist ☐Give ☐Req. Special Food/Liq ________________

☐Can Swim? ☐Can't Swim But Enjoys Water

Special Needs/Cares

☐Dressings/Wound Care ________________

☐Diabetic ☐Oral ☐Insulin ☐Pump

☐Incontinent ☐Bed Wets ☐Diaper

☐Catheter ☐Self-Assist ☐Self Cath

☐Catheterization Frequency ________________

☐Tube Feeding: What/Frequency ________________

Camper's Name ___________________________________

Persons to Contact in an Emergency (Please provide two)

Name ____________________ Relationship ____________________

Home Phone ____________________ Work ____________________Cell ____________________

Name ____________________ Relationship ____________________

Home Phone ____________________ Work ____________________Cell ____________________

I am the parent or legal guardian of the minor child listed above in Camper Information. I agree that I have accurately provided this information and certify that I am the appropriate person to provide a medical history for my child. I understand that DCI will make treatment decisions based on the information I have provided on this form.

Signed:

____
Patient's Name (printed)

____
Parent/Guardian Name (printed)

____
Parent/Guardian Signature

____
Date

Health Care Provider Verification:

____
Name, Title

____
Contact Phone Number

____
Date

Health Information to be Completed by Dialysis Health Care Provider

NOTE: Health Information not required for children of counselors. Insurance card must still be provided in case of emergency. Progress note within 60 days of camp must be submitted.

Problem List (please list)

1 ____
2 ____
3 ____
4 ____
5 ____
6 ____
7 ____
8 ____
9 ____

Lab Date ____________ Hbg ________ HCT ________ K+ ________ BUN ________ CR ________

FK ________ Prograf ________ CyA ________ Rapimmune ________ Neoral ________

Transplant Date ______________________ ESRD ____________________ Started _____

Date of Last Hospitalization ____________________ Reason ______________________________

Diet ______________________________ Allergies______________________________

Special Diet Needs ______________________ Etiology CRF ______________________________

Camper's Name ___________________________________

Medication Information

Please enter dosage as strength (i.e. – 500 mg) instead of amount (i.e. – 1 tablet). Specify the exact time.
DO NOT USE "take 2 a day" or "AM PM". See examples below.

Medication	Classification	Dosage	Time to Administer (HH:MM am/pm)	Special Instructions
EXAMPLE #1 **Renagel**		**336 mg**	**5AM 12PM 5PM**	**Take 6 tablets**
EXAMPLE #2 **Prednisone**	**Steroid**	**2.5 mg**	**8AM 8PM**	**Take 2.5 tablets – 1 mg**

Camper's Name ___________________________________

Referring Facility ______________________________

Phone ____________________ Fax ____________________

Address ____

City ____________________ State ________ Zip __________

Primary Nurse ______________________________

Social Worker ______________________________

Primary Nephrologist ______________________________

Phone ____________________ Fax ____________________

I am the health care provider for the minor child listed above in Camper Information. I agree that I have accurately provided the above medical information for this child.

Signed:

____
Name of Dialysis Health Care Provider Company (printed)

____
Name & Title of Person Completing this Form (printed)

____
Signature of Person Completing this Form

____
Date

Specific Health Information Contact:

____
Contact Name

____
Contact Phone Number

*****INSURANCE CARD MUST ACCOMPANY HEALTH INFORMATION*****

Camper's Name ___________________________________

PERMISSION for CAMP ATTENDANCE and RELEASE OF LIABILITY

Camper Name ____ SS# ____________________

I am the parent or legal guardian of the minor child listed above in Camper Information. (If I am a legal guardian, I understand I must submit the court order regarding appointment of guardianship of the child before this consent may become effective.) I give my child or ward permission and agree that my child may be a resident at Camp Okawehna from _____________________________. I understand residing at Camp Okawehna includes sleeping, eating, engaging in voluntary activities and receiving dialysis treatments at the Camp. I understand that my child may be participating in multiple physical activities throughout the week, including canoeing, obstacle courses, swimming, nature walks and basketball. I am aware that all activities are voluntary and understand that I may review the activities from last year's camp on the web site, *www.dciinc.org*, to obtain further information.

I agree to indemnify and hold the United Methodist Church's Camp Cedarcrest, and DCI, its agents or employees, harmless from all claims, damages, liabilities, judgments, including reasonable attorney fees, which DCI may incur arising out of any occurrence during this child's stay at Camp Okawehna.

Signed:	**Witness:**
____________________	____________________
Patient's Name (printed)	Name
____________________	____________________
Guardian's name, if applicable (printed)	Signature
____________________	____________________
Patient/Guardian Signature	Title
__________	__________
Date	Date

Camper's Name ___________________________________

CAMP CONTRACT

All Campers **and their parents or guardian are** required to sign the **Camp Okawehna** contract of conduct. **Campers who are unable to follow the rules of camp, or are disruptive and interfere with the camp experience of other campers may be asked to leave camp and return home.**

Rules and Regulations of Camp Okawehna

1. Everyone should have a good time while at Camp.
2. Everyone is expected to help make camp an enjoyable experience for one another.
3. Everyone should walk; the golf carts are for emergencies only.
4. All campers must be accompanied by an adult staff member to and from all activities.
5. Campers should not enter another camper's cabin without the presence of a cabin counselor.
6. All campers are expected to participate in the cabin activities throughout the entire week while at camp.
7. **The use of electronic equipment (MP3 players, portable game systems, etc.) is not allowed at camp.** Any electronic equipment taken to camp will be held in a secure area and returned upon departure from camp at the end of the week.
8. **Only disposable cameras will be allowed at camp and should be labeled with the camper's name.**
9. Respect should be shown to camp counselors, staff, visitors, other campers and their property.
10. Lights out means lights out. You must remain quietly in your assigned cabin after lights out.
11. The possession of alcohol tobacco or any illegal drugs is prohibited.

I agree to abide by the rules and regulations of Camp Okawehna. I understand that if I fail to abide by the rules I may be **asked to leave camp and return home.** This may impact my ability in the future to return to camp.

Signed:

______________________________	______________________________
Camper Name (printed)	Parent/Guardian Name
______________________________	______________________________
Camper Signature	Parent/Guardian Signature
__________	__________
Date	Date

Camper's Name ___________________________________

MEDIA AUTHORIZATION

Camper Name ______________________________________ SS# ____________________

I authorize Dialysis Clinic, Inc., its agents and employees to take any photographs, films and videos of my child while attending camp; to include during dialysis treatment. Additionally, I agree to allow my child to be interviewed by television or radio personnel. I understand and agree that these photographs, films and videos may be used in the media, including newspapers, magazines, and publications, educational materials, and on the DCI web site, and they may be viewed by the general public. I understand that information including, but not limited too my child's name, age and medical condition may be included in the media materials. I also understand that I will receive no compensation or money for the use of my child's photographs, films or videos; nor will I be charged anything. I understand that I will have no ownership or property rights in any photographs, films or videos taken of my child. I further agree to hold Dialysis Clinic, Inc., its agents, officers, employees harmless from any liability connected with the use of photographs, films or videos and with the release of any information related to my child's medical condition.

DCI will not condition your right to treatment or payment on your granting this requested authorization. You have the right to refuse to sign this authorization. Except to the extent that we have already relied on it, you have the right to revoke this authorization by doing so in writing addressed to the following:

DCI Corporate HIPAA Officer
1633 Church St., Suite 500
Nashville, TN 37203

A photocopy of this authorization shall have the same force and effect as the original. This authorization never expires. The information used or disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by the regulations that require health care providers to protect individually identifiable health information.

I certify that I have read (or had read to me) the above authorization and that I fully understand the nature and purpose of this authorization. I have had the opportunity to ask and have answered any questions that I may have regarding the information contained in this authorization form. I also certify that I am the patient or the patient's duly authorized agent or representative and that I am authorized to execute this authorization.

Signed:	**Witness:**
______________________	______________________
Patient's Name (printed)	Name
______________________	______________________
Parent/Guardian Name (printed)	Signature
______________________	__________
Parent/Guardian Signature	Title
__________	__________
Date	Date

Camper's Name ___________________________________

CONSENT FOR EMERGENCY MEDICAL TREATMENT

Camper Name ____ SS# ____________________

EMERGENCY MEDICAL TREATMENT

I am the parent or legal guardian of the minor child listed above in Camper Information. (If I am a legal guardian, I understand I must submit the court order regarding appointment of guardianship of the child before this consent may become effective.) On behalf of my child or ward, I consent for Dialysis Clinic, Inc. ("DCI") to provide and seek any emergency medical care and treatment for my child while he/she is a resident at Camp Okawehna. I understand and agree that if DCI deems that my child needs emergency medical treatment, DCI will utilize Hickman County emergency services for ambulance transportation to a hospital. If DCI deems that ambulance transport is unnecessary, but emergency medical treatment is needed, then DCI will transport my child by car to a local hospital and seek an emergency evaluation and treatment. I agree to indemnify and hold DCI harmless from any and all claims, damages, liabilities, judgments, including reasonable attorney fees, arising out of emergency medical treatment sought and provided to my child.

Signed:	**Witness:**
________________________________	________________________________
Patient's Name (printed)	Name
________________________________	________________________________
Guardian's name, if applicable (printed)	Signature
________________________________	________________________________
Patient/Guardian Signature	Title
__________	__________
Date	Date

NOTE: Not required for children of counselors.

Camper's Name ___________________________________

CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I give my consent for Dialysis Clinic, Inc. ("DCI") to use and/or disclose information from and/or copies of all or any part of my health record for the following purposes:

1. Treatment -
   I consent for DCI to use or disclose my health information to any physician, hospital, or other health care provider in order to treat me;

2. Payment -
   I consent for DCI to use or disclose my health information to any person, corporation, agency, or other entity (or the agent or designee of any such person, corporation, agency, or other entity) which is legally responsible, or which DCI has good cause to believe is legally responsible, for all the payment for the medical services, medication, and supplies DCI provides to me; and

3. Health Care Operations -
   I consent for DCI to use or disclose my health information for routine health care operations, such as assessing quality of care and reviewing staffing requirements.

I also give my consent for DCI to obtain copies of my health information from:

1. Any and all physicians, hospitals, and other health care providers; and

2. Any and all persons, corporations, agencies, and other entities that are legally responsible for the payment of all or any part of the medical services, medications, and supplies that DCI provides to me.

I understand for purposes of this consent that the term "health record" means medical information or documentation that relates to:

1. my past, present, or future physical and/or mental health or condition;

2. the provision of health services to me; and

3. payment of all or any part of the medical services, medications, and supplies that DCI provides to me

This consent specifically includes and allows the use and disclosure of any information from or copies of my health record which may include treatment for mental illnesses and

NOTE: Not required for children of counselors.

Camper's Name ___________________________________

CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

psychiatric conditions, for drug or alcohol abuse, drug-related conditions, alcoholism, HIV testing results, and the treatment or diagnosis of AIDS or an AIDS-related condition.

This consent will be valid when I sign it and will remain in effect unless revoked in writing. I understand that I may revoke this consent, but if I do so it may adversely affect DCI's ability to treat me appropriately, and as a result, DCI may not continue to provide my dialysis care.

I hereby waive any requirement that this consent be addressed to any specific person or institution or that it be dated within any particular period of time before a request is made.

Any determination that any provision of this consent is invalid, illegal, or unenforceable shall not affect the validity, legality, or enforceability of any other provision contained herein.

A photocopy of this consent shall have the same force and effect as the original.

I certify that I have read (or had read to me) the above consent and that I fully understand the nature and purpose of this consent. I have had the opportunity to ask and have answered any questions that I may have regarding the information contained in this consent form. I also certify that I am the patient or the patient's duly authorized agent or representative and that I am authorized to execute this consent.

Signed:	**Witness**:
______________________________	______________________________
Patient's Name (printed)	Name
______________________________	______________________________
Guardian's name, if applicable (printed)	Signature
______________________________	______________________________
Patient/Guardian Signature	Title
__________	__________
Date	Date

Version Approved 12/18/02

NOTE: Not required for children of counselors.

Camper's Name ________________________________

Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

To effectively treat you, Dialysis Clinic, Inc. (DCI) must collect health information about you and furnish it to other people. Your health information is private and confidential. We have policies and procedures to protect your health information. This notice describes what types of information we collect. It also explains when and to whom we may give your health information, and provides you with other important information. This notice is not a contract which forms the basis of any private right of action.

YOUR HEALTH INFORMATION RIGHTS

Your health record belongs to DCI, but you have the right to request in writing:

- to limit certain uses and disclosures of your health information
- to obtain a copy of this "Notice of Health Information Practices"
- to review and obtain a copy of your health records (DCI has 30 days to respond to your request)
- to change your health record if you believe it is incomplete or incorrect (DCI has 60 days to respond to your request)
- to obtain a list of when your health record has been given to others (DCI has 90 days to respond to your request)
- to receive your health information from the clinic in a different way than the clinic would normally furnish it

In order to exercise any of these rights, contact your clinic's Privacy Officer.

DCI RESPONSIBILITIES

By law, DCI is required to:

- keep your health information private
- give you this *"Notice of Health Information Practices"*
- abide by the Notice currently in effect
- only use or disclose your health information with your written consent, except as described in this notice.

We reserve the right to change our health information practices. If our practices change, we will make available a copy of the changes.

TYPES OF USES AND DISCLOSURES OF YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

DCI will use or disclose your health information <u>without further permission from you</u> for treatment, payment, and operations purposes. The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed.

NOTE: Not required for children of counselors.

Camper's Name ___________________________________

We will use and share your health information for **TREATMENT PURPOSES** with any other clinic or health care provider that needs the information for purposes of treating you.

We will use and share your health information for **PAYMENT PURPOSES**:

- for DCI activities directly related to being paid for its health care services, (for example, we would file a claim with an insurance company who would in turn pay us for your treatments),
- for DCI's own payment purposes or to another clinic or health care provider for its payment purposes,
- but, we will never share health care information with a non-health care provider for payment activities, (for example, we would never share information with one of your creditors).

We will use share your health information for health care **OPERATIONS PURPOSES** in order to:

- assess and improve the quality of care of DCI patients
- review the qualifications and competence of any health care professionals such as doctors who might care for you
- train students, other health care professionals or non-health care professionals , to learn and improve their skills in dialysis
- receive accreditation, certification and licensing
- credential DCI and non-DCI staff
- conduct or arrange for medical review, legal services, and auditing functions, including DCI's compliance program
- engage in business management, administration, planning , and development
- resolve internal grievances
- use your health information in a manner that does not identify you
- complete a sale, transfer, or consolidation of clinic assets with another provider

TYPES OF ADDITIONAL USES OF YOUR HEALTH INFORMATION

In these additional situations, DCI may also release your health information <u>without your permission</u>:

Business Associates: DCI provides some services through contracts with business associates, such as medical directors, accountants, and computer consultants. We may disclose your health information to our business associates so they can perform their jobs. By contract, we require our business associates to safeguard your health information.

Notification of Your Location and General Condition: In an emergency, or if you are absent or incompetent, we may need to notify a family member, personal representative or another person responsible for your care of your location and general condition.

Communication with Family: In an emergency, or if you are absent or incompetent, we may discuss your general condition/location and/or payment issues with a family member, other relative, close personal friend, or any other person you identify.

Camper's Name ________________________________

Research: We provide information to persons or organizations conducting research if an Institutional Review Board (IRB) has approved their study. The IRB reviews the research study and makes rules to ensure the privacy of your health information.

Funeral Directors, Coroners, and Medical Examiners: We may provide health information to funeral directors, coroners, and medical examiners for them to carry out their duties.

Organ Procurement Organizations, Tissue and Eye Banks: We may furnish health information to agencies engaged in the procurement, processing, distribution, or transplantation of organs for the purpose of donation and transplant.

Appointment Reminders: We may contact you to provide appointment reminders.

Food and Drug Administration (FDA): We may provide your health information to the FDA to report adverse events regarding food supplements and/or product defects. Your health information may also be provided to report product recalls, repairs, or replacements.

Workers' Compensation: We may provide health information as authorized by laws relating to workers' compensation or other similar programs.

Public Health: As required by law, we may furnish your health information to public health or legal authorities charged with preventing or controlling neglect, abuse, disease, injury, disability, or death.

Correctional Institution: If you are an inmate of a correctional institution, we may provide your health information to the institution or its agents.

Law Enforcement: We may furnish health information for law enforcement purposes:

- as required by law or in response to a valid subpoena or administrative request
- for identification and location purposes
- if you are suspected to be a victim of a crime
- in the event of suspected criminal conduct on our premises

Health Oversight Activities: We may provide your health information to organizations that ensure we follow health care laws and regulations.

Judicial and Administrative Proceedings: We may furnish health information in response to a court order or other legal process.

As required by law: We will disclose medical information about you when required to do so by federal, state, or local law.

OTHER USES OF YOUR HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose health information about you, you may later revoke that authorization in writing. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. We are unable, however, to take back any disclosures we already have made with your permission. Also we are required to retain our records of the care that we provided to you.

NOTE: Not required for children of counselors.

Camper's Name ___________________________________

TO REPORT A PRIVACY RIGHT VIOLATION

If you believe your privacy rights have been violated, you may file a complaint with your clinic's Privacy Officer or with the Secretary of Health and Human Services. DCI will not retaliate against you for filing a complaint. Complaints must be filed with the Secretary of Health and Human Services as provided by 45 CFR 160.306b.

If you have any questions about this notice, would like more information, or would like to exercise your rights, please contact your clinic's Privacy Officer. Your clinic's Privacy Officer may be reached as follows:

To:	DCI Corporate HIPAA Privacy Officer
Address:	1633 Church St, Suite 500, Nashville TN 37203
Phone:	877-326-1109
Fax:	615-321-6418

I have read (or had read to me) the information in this *"Notice of Health Information Practices"*. I have had the opportunity to ask, and have answered, my questions regarding the use of my health information. I understand that this Notice is provided to comply with federal law. It does not create any additional rights or remedies or a private cause of action.

Signed:	**Witness:**
______________________________	______________________________
Patient's Name (printed)	Name
______________________________	______________________________
Guardian's name, if applicable (printed)	Signature
______________________________	______________________________
Patient/Guardian Signature	Title
___________	___________
Date	Date