# HEMODIALYSIS CAMPER APPLICATION

Submit by email to Glenda.Streicher@dciinc.org
or by fax (615) 341-8814 to Attn: "Camp O Processing Dept"

**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.***

Date: _____

*****All campers MUST provide COVID vaccine and booster documentation and a negative PCR test within 72 hours of Camp.**

**Camper Information**

Name (First, Last, MI) _____

Date of Birth _____ Sex _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work/Cell Phone _____

Email Address _____

T-shirt Sizes: ◯ XS ◯ S ◯ M ◯ L ◯ XL ◯ 2XL ◯ 3XL ◯ Child ◯ Adult

Height: _____ ◯ cm ◯ ft/inches Weight: _____ ◯ kg ◯ lbs

Please check all that apply:

☐ History of seizures?
- Date of Last Seizures
- ☐ Seizure Medication (list on Medication Form)

☐ Problems breathing?
- What disease? _____
- ☐ Inhaler ☐ Sp. Equipment

☐ Social/Behavioral Issues?
- ☐ Overnight stay w/o parent/family
- ☐ Medication (list on Medication Form)

☐ Hearing problems?
- ☐ Hearing Aid (☐ Left ☐ Right)

☐ History of Heart disease?
- What disease? _____
- ☐ Medication (list on Medication Form)

☐ Learning disabilities?
- ☐ Unable to read
- ☐ Language barrier
- Primary Language _____

☐ Vision impairment?
- ☐ Glasses ☐ Contacts

☐ Read lips

☐ Sign language

**Physical Limitations**

Describe _____

_____

☐ Growth hormone
☐ Uses crutches?
☐ Can walk up hills?
☐ Uses wheelchair?
☐ Walk 1/2 mile?
☐ Can take own meds?
☐ Can swim?
☐ Can't swim but enjoys water
☐ Assist ☐ Give
☐ Required special food/liq: _____

Camper's Name _____

**Special Needs/Cares**

☐ Dressings/Wound Care: _____

☐ Diabetic ☐ Oral ☐ Insulin ☐ Pump

☐ Incontinence ☐ Catheter-self/assist ☐ Bed Wets ☐ Diaper

☐ Frequent nausea/vomiting ☐ Diarrhea/constipation

☐ Tube feeding: what/frequency _____

**Persons to Contact in an Emergency** (Please provide two)

1. Name _____
   Home Phone _____
   Relationship _____
   Work/Cell Phone _____

2. Name _____
   Home Phone _____
   Relationship _____
   Work/Cell Phone _____

**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**

Please list out any existing health problems

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

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 _____

# MEDICATION INFORMATION

Camper's Name _____

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 - 1mg* |
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Camper's Name _____

**Complete only if camper will be receiving hemodialysis at camp:**

NOTE: Camp Okawehna will only provide F6, F160NR, and 180NR dialyzers. If you require another type of dialyzer, please list it below and bring four of these dialyzers with you to camp. Dialysate bath will be available in 2K/2Ca. Special bath will be prepared on site for increase in K or Ca.

Dialyzer _____ Machine temp _____

Blood lines ◯ Ped ◯ Adult Crit-line ◯ Yes ◯ No

Blood flow prescribed _____ Dialysate flow _____

Times per week _____ Dialysate _____

Time _____ Est. Dry Weight _____ ◯ kg ◯ lbs

Heparin Bolus _____ Heparin Infusion _____

Units per hour _____ Discontinue _____hr____min before Tx end

Na _____ HCO3 _____ Profile linear/step: Start Na _____ End Na _____

**Vascular Access Information**

Type _____ Location _____ Secondary _____

Local Anesthetic _____ Usual Venous Pressure _____

Needle Gauge _____ Heparin Strength Cath 1000/5000 units

Volume: Arterial _____ Venous _____ ☐ Button Hole Needle

Other special cannulation considerations (i.e. self-cannulation): _____

_____

**Other Information**

Allergies _____

Usual BP Support Methods _____

Special needs or circumstances relative to transient visit _____

_____

Camper's Name _____

**Referring Facility Information**

Referring Facility: _____

Phone _____ Fax _____

Address _____

City _____ State _____ Zip _____

Primary Nurse _____

Social Worker _____

Primary Nephrologist _____

Phone _____ Fax _____

I am the dialysis health care provider for the individual listed as Counselor. I agree that I have accurately provided the above medical information for this individual.

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***

# PERMISSION FOR CAMP ATTENDANCE AND RELEASE OF LIABILITY

Campers Name _____

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 Cedar Crest, 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:

_____
Patient's Name (printed)

_____
Guardian's name, if applicable (printed)

_____
Patient's/Guardian Signature

Date _____

Witnessed:

_____
Name

_____
Signature

_____
Title

Date _____

# 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's Name (printed) | Parent/Guardian Name (printed) |
| Camper's Signature | Parent/Guardian Signature |
| Date _____ | Date _____ |

# MEDIA AUTHORIZATION

Campers Name _____

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:

_____
Patient's Name (printed)

_____
Guardian's name, if applicable (printed)

_____
Patient's/Guardian Signature

Date _____

Witnessed:

_____
Name

_____
Signature

_____
Title

Date _____

# CONSENT FOR HEMODIALYSIS TREATMENT AND EMERGENCY MEDICAL TREATMENT

Campers Name _____

**HEMODIALYSIS 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 hemodialysis treatments for my child while he/she is a camp resident at Camp Okawehna. I understand that an attending physician and dialysis nurse ("caregivers") will be assigned to my child.

I have been advised by my child's physician that he/she has chronic renal failure, which requires dialysis to carry out the functions that my child's kidneys are no longer able to perform. One form of dialysis is hemodialysis which my child's physician has fully explained to me its nature, purpose, risks, possible and likely consequences or complications, as well as alternative methods of treatment including but not limited to (1) home hemodialysis; (2) peritoneal dialysis; and (3) transplantation.

I understand that in addition to the particular risks of hemodialysis treatment, there are risks, including but not limited to, infection, muscle cramps, nausea and vomiting, headaches, low blood pressure, irregular heartbeat, bleeding and clotted blood vessel access. I acknowledge that these adverse reactions may range from mild reaction to death. I recognize that I have the option to refuse for my child to undergo any type of treatment. However, I also understand that if I refuse any treatment on behalf of my child, DCI can no longer adequately meet my child's needs and he/she must leave Camp Okawehna immediately and return to my care. Therefore, I have decided to consent for my child to undergo hemodialysis treatments in the dialysis facility at Camp Okawehna while my child is a camp resident.

I understand that my child's prescribed treatment, medication or procedure will be administered to him/her under the direction of the caregivers and I consent to the administration of such treatment, medication or procedure as they may consider necessary or advisable. I understand that possible side effects, including, but not limited to, death, cardiac arrest, adverse drug reactions, respiratory problems, damage to arteries or veins, headaches and pain and discomfort are risks associated with the treatment, medication or procedure necessary or advisable to treat my child's condition.

**EMERGENCY MEDICAL TREATMENT**

I also consent to any emergency medical care and treatment for my child. 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, DCI will transport my child by car to a local hospital. 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. Any changes not covered by my insurance will be billed to me by the facility providers care to my child.

**MY SIGNATURE BELOW ACKNOWLEDGES THAT (1) I HAVE READ, UNDERSTAND AND AGREE TO THE STATEMENTS SET FORTH IN THIS DOCUMENT; (2) A CAREGIVER HAS EXPLAINED TO ME ALL INFORMATION REFERRED IN THIS DOCUMENT; AND (3) NO GUARANTEES OR ASSURANCES CONCERNING THE RESULTS OF ANY PROCEDURE OR TREATMENT HAVE BEEN MADE.**

Signed:

_____
Patient's Name (printed)

_____
Guardian's name, if applicable (printed)

_____
Patient's/Guardian Signature

Date _____

Witnessed:

_____
Name

_____
Signature

_____
Title

Date _____

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

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 |

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.** This is your record to keep, does not need to be returned with application.

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.

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.

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:

_____
Patient's Name (printed)

_____
Guardian's name, if applicable (printed)

_____
Patient/Guardian Signature

_____
Date

**Witness:**

_____
Name

_____
Signature

_____
Title

_____
Date

Camper's Name _____

# ASSIGNMENT OF BENEFITS TO DIALYSIS CLINIC, INC.

I,_____, hereby make a direct assignment of my insurance rights and benefits to Dialysis Clinic, Inc. ("DCI"), and instruct _____ _____to pay directly to DCI any and all sums due to me under the attached claim(s). I further instruct that said payment be sent to DCI at the following address:

**Dialysis Clinic, Inc.**
**1633 Church Street**
**Suite 500**
**Nashville, TN 37203**

A photocopy of this assignment shall be considered as effective and valid as the original, and this authorization is in effect until I choose to revoke it.

If my current policy prohibits direct payment, then I hereby instruct and direct you to make out the check to me and mail it as follows:

**c/o Dialysis Clinic, Inc.**

**1633 Church St.**
**Suite 500**
**Nashville, TN 37203**
(Clinic Address)

Signed:

_____
Patient's Name (printed)

_____
Guardian's name, if applicable (printed)

_____
Patient/Guardian Signature

_____
**Medicare Number or Policy Number**

_____
Date

**Witness:**

_____
Witness Name

_____
Witness Signature

_____
Title

_____
Date

Modified 7.24.2017

Camper Name: _____ Session: _____

# Pre-Camp Health Screening

Dear Camp families,

In an effort to minimize illness at camp we ask that you check on the health of your camper daily beginning 14 days prior to camp. The best camp sessions start with healthy campers and this begins at home. Please bring this completed form to camp on opening day.

**Please indicate if your camper has any of the following symptoms prior to camp and record a temperature daily. If any temperature or symptoms are present, please have your camper evaluated by a licensed provider and contact camp for further guidance.**

**Symptoms (symp):**

- Cough
- Shortness of breath or difficulty breathing
- Fever
- Chills
- Muscle Pain
- Sore throat
- New loss of taste or smell
- Nausea
- Vomiting
- Diarrhea

**Please initial**

**1. My child has not been around anyone with any of the listed symptoms or diagnosis of COVID19 in the 14 days before the start of camp. Initial _____**

**2. No one in our household has been sick in the 14 days prior to camp. Initial _____**

**3. My child has not traveled by air or traveled out of state in the 14 days prior to camp. Initial _____**

**4. My child has adhered to our state's guidelines regarding COVID19. Initial _____**

Start date of temperature/ symptom screening:

_____

| **Day:** | **14** | **13** | **12** | **11** | **10** | **9** | **8** |
|---|---|---|---|---|---|---|---|
| Temp/ symp | | | | | | | |
| **Day:** | **7** | **6** | **5** | **4** | **3** | **2** | **1** |
| Temp/ symp | | | | | | | |

*Our signature indicates that we completed this health screening daily for 14 days prior to camp and to the best of our ability. We understand that arriving to camp healthy is vital to a healthy camp for all campers.*

Parent Signature: _____Date:_____

Camper Signature: _____Date:_____

*created by Eleanor Matthews, RN 2020*

# CAMP OKAWEHNA COVID-19 TESTING CONSENT FOR CAMPERS

Camp Okawehna (Camp O) is taking measures through its COVID-19 mitigation plan to help keep our camp community safe. The mitigation plan includes COVID-19 testing in the event a child is symptomatic or the Camp O care team determines that a child needs to be tested due to contact with another camper positive for or is suspected to have COVID-19. If your child's test results are positive, you will be contacted and the camp medical staff will take necessary steps to maintain a safe camp environment.

Although important, the mitigation plan cannot eliminate the potential for exposure to COVID-19 or any other illness while at camp. Additionally, please remember that you need to have your child tested for COVID-19 within 72 hours prior to their coming to camp and provide the negative result of the test to your city group leaders before coming to the camp with your city group.

We are requesting your consent as parent or guardian to test your child for COVID-19. This COVID-19 Consent Form supplements the Camp O Camper Application packet, including its Permission for Camp Attendance and Release of Liability.

Testing will be a diagnostic antigen or PCR test for COVID-19.

Information about your camper and his or her test results will be shared with and among certain agencies and providers to support the testing program, for public health purposes, for use of Camp O staff to use in facilitating treatment for your child, if necessary, for use implementing isolation, quarantine, or other changes to your child's camp experience, and for contact tracing in order to reduce further infections. Sharing of information about your child will be done in accordance with applicable law and our policies protecting camper privacy.

## CONSENT FOR TESTING

By filling out the form and signing below:

- I consent for my camper to be tested for COVID-19 infection.
- I understand that this consent form will be valid through my child's stay at camp.
- I understand that my camper's test results and other information may be disclosed as specified above and as permitted by law.
- I have signed this form freely and voluntarily, and I am legally authorized to make decisions for and consent on behalf of the camper named below.
- I understand that if I am 18 or older or may otherwise legally consent for my own health care, references to "camper" refer to me and I may sign this form on my own behalf.

TO BE COMPLETED BY PARENT or GUARDIAN: (Please Print)

Camper Name: _____

Signature: _____ Date: _____

Printed Parent/Guardian Name: _____