FEBRUARY 3-6, 2011

APPLICATION

Deadline for application is:
December 27, 2010
We WILL NOT admit a camper without this COMPLETED form being in our possession BEFORE arriving at camp.

CAMPERS MUST BE 11 TO 17 YEARS OF AGE

PLEASE INCLUDE A CURRENT PHOTO!!!!!

PLEASE PRINT OR TYPE

Name____

Birth date: __________ Age: ___ Sex: _____ School Grade: _____________
E-Mail Address: _________________ Adult T-shirt size: ____________________

Home: ____
City: ____
State: _______________________Zip: _____________

Parents email: ____
Home Telephone: (   )_____________________ Other Phone: ________________

Mother's Name: ____
Occupation: _________________Employer:____________________________
Work Phone (   )_____________________________

Father's Name: ________________

Occupation: __________________ Employer:________________________________
Work Phone: (   ) _____________________________

BELOW MUST BE SIGNED BY PARENT BEFORE DOCTOR WILL TREAT

PARENT'S AUTHORIZATION In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the Camp Director to secure proper medical and surgical treatment, including diagnostic tests for my child as named below.

Child's Name:

____

Print Parent or
Legal Guardian Name: ____

Parent's Signature: ____

Date: ____

EMERGENCY CONTACT INFORMATION

NOTE: This should be a person who will know your whereabouts at all times.

Name: ________________________ Phone ( )____________________

Name:________________________ Phone ( )____________________

PCP Name: ________________________ Phone: ( ) ___________________

Name of Camper's Health Insurance: ____

Phone No: ( ) ___________________

Subscriber No: ____________________ Group No: ___________________

AGREEMENT AND RELEASE

In consideration of Portland Firefighters Children's Burn Foundation (hereafter called "Foundation"), undertaking a program of camping of therapeutic benefit for the health and welfare of: ____ (student's name) (hereafter called "Student") and activities incidental thereto, including transportation provided by the Foundation to and from Camden Snow Bowl at the request of the undersigned acting on behalf of all the Student's parents or guardians, the undersigned agrees, represents and certifies as follows:

1 The undersigned is a parent or legal guardian of the above named Student and has full and complete authority from all parents or legal guardians of the Student to execute this agreement on behalf of said parents or legal guardians.

2 It is recognized that the Student's participation in the camping experience mentioned above and related activities involves risk of bodily injury and property loss and damage incidental to such type of activities, and it is agreed that the risk of any such injury, loss and damage is assumed by the Student and all of the Student's parents or legal guardians.

3 The undersigned and all of the Student's parents or legal guardians individually and as such parents or guardians, hereby remise, release and forever discharge the owners and operators of The Camp and The Foundation and their respective officers, agents, employees and representatives, of and from all liability, claims or demands resulting from, participation in the above mentioned activities, including by way of illustration but not limitation, injury, loss or damage occurring during travel to and from the camp, activities held therein, overnights, and during meals, rest and waiting periods. The undersigned and all of the Student's parents or operators of The Camp and the Foundation and their respective officers, agents, employees and representatives, from and against any loss, damages or cost, including reasonable attorney's fees, that may be incurred as a result of any such action, claim or demand except for acts of their own negligence.

4 Camp Staff and the Foundation are hereby instructed and authorized to employ such emergency medical treatment as they see fit during the Student's participation in any of the above mentioned activities, if, in their sole judgment; the condition of the Student, because of injury, illness, or otherwise requires such emergency treatment, and the Foundation.

The Camp and their respective officers, agents, employees and representatives, are hereby released from any liability for all their decisions and actions, made and done in good faith, in administering such emergency medical treatment.

Dated at ________________________________ this ______________day of ______________________20______ City and State _________________

Print Name of Parent or Legal Guardian:_____________________________________

Signature of Parent or Legal Guardian: ______________________________________

Witness:_______________

PLEASE BE SURE TO HAVE WITNESS SIGN THIS PAGE

PERMISSION TO CONTACT

I hereby grant permission for the release of my child's name, address, and phone number to other children who attend Winter Burn Camp. Campers may contact counselors through the foundation office and their letters will be forwarded.

Permission is further granted for other children to correspond with and telephone my child. Any personal visits must first be approved by the undersigned.

Campers Name: ____

Parent/Guardian Name: ______________________________________

Parent or Legal Guardian Signature ______________________________

Witness to your signature (anyone over 18) _________________________

Date __________________

PHOTOGRAPHIC RELEASE

I hereby grant permission for the taking of photographs and/or the release of general information regarding

Camper's Name: ________________________

Date of Camp: __________________________

The photograph(s) and or general information may be used as needed in the administration of Fire & Ice Winter Burn Camp and/or may be published in, or used by, and the media or Portland Firefighters Children's Burn Foundation, publications, including newspapers, magazine, television, radio, pamphlets, brochures, report, etc.), without any liability on the part of the camp, the Portland Firefighters Children's Burn Foundation, their agents or employees.

Parent or Legal Guardian Signature Witness to Signature (anyone over 18)

SIGN: _______________________________ Date: ____________

WITNESS: ____________________________ Date: ____________

Dear DOCTOR:

THESE 4 PAGES ARE TO BE COMPLETED BY A LICENSED M.D. AND RETURNED TO OUR OFFICE PRIOR TO CAMPER ARRIVING AT CAMP.

The child's Burn Surgeon, Pediatrician or Family Physician can complete this form with updated information. The form must be signed by physician and returned to:

Portland Firefighters Children's Burn Foundation
380 Congress Street
Portland, ME 04101

The purpose of this report is to ascertain whether the camper can:
a) engage in strenuous activity at high altitudes;
b) has been exposed or has a communicable disease that could be conveyed to others;
c) has a medical, physical or emotional condition needing the special attention of the camp staff.

Physician Name: ____
Telephone: (   )______________________
M.D. License #__________________________________
Date: ________________ Physician's Signature: _____________________________

If the camper has had a physical examination in the past year, he or she does not need another physical unless there is a change in their health status. However, we must have a completed and signed form

Camper's Name: ____

Does the camper have any significant :

Medical Condition	Yes No
Physical Condition	Yes No
Emotional Condition	Yes No
Communicable Disease	Yes No
Allergic Condition	Yes No

If yes, to any of the above, please explain the condition/disease and treatment:

Are the camper's immunizations current? Yes ____ No ____ See attached forms.

List any life threatening allergies (for example: Latex, peanuts, bees, horses, and/or medication allergies)
____

Antidote ____________________________ and Dose______________________
Antidote ____________________________ and Dose______________________
Antidote ____________________________ and Dose______________________

Does this patient have any heart problems or asthma that may be affected
by strenuous activity? Yes No

If yes, please list:

This Physician's signature authorizes occupational therapy, physical therapy, any routine wound care, administration of prescribed medication (according to the bottle and/or written specifics) and administration of Over The Counter medications.

Examining Physician:
____ Please Print

Address: ____

City/State/Zip: ____

Vaccine Administration Record for Children and Teens

Patient name: ____________________

Birthdate: ____________________

Chart number: ____________________

Before administering any vaccines, give copies of all pertinent Vaccine Information Statements (VISs) to the child's parent or legal representative and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine[1]	Date given (mo/day/yr)	Funding Source (F,S,P)[2]	Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials & title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Hepatitis B[6] (e.g., HepB, Hib-HepB, DTaP-HepB-IPV) Give IM.[7]									
Diphtheria, Tetanus, Pertussis[6] (e.g., DTaP, DTaP/Hib, DTaP-HepB-IPV, DT, DTaP-IPV/Hib, Tdap, DTaP-IPV, Td) Give IM.[7]									
***Haemophilus influenzae* type b[6]** (e.g., Hib, Hib-HepB, DTaP-IPV/Hib, DTaP/Hib) Give IM.[7]									
Polio[6] (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV) Give IPV SC or IM.[7] Give all others IM.[7]									
Pneumococcal (e.g., PCV7, PCV13, conjugate; PPSV23, polysaccharide) Give PCV IM.[7] Give PPSV SC or IM.[7]									
Rotavirus (RV1, RV5) Give orally (po).									

See page 2 to record measles-mumps-rubella, varicella, hepatitis A, meningococcal, HPV, influenza, and other vaccines (e.g., travel vaccines).

How to Complete This Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the site where vaccine was administered as either RA (right arm), LA (left arm), RT (right thigh), LT (left thigh), or IN (intranasal).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
6. For combination vaccines, fill in a row for each antigen in the combination.
7. IM is the abbreviation for intramuscular; SC is the abbreviation for subcutaneous.

Abbreviation	Trade Name & Manufacturer
DTaP	Daptacel (sanofi); Infanrix (GlaxoSmithKline [GSK]); Tripedia (sanofi pasteur)
DT (pediatric)	Generic (sanofi pasteur)
DTaP-HepB-IPV	Pediarix (GSK)
DTaP/Hib	TriHIBit (sanofi pasteur)
DTaP-IPV/Hib	Pentacel (sanofi pasteur)
DTaP-IPV	Kinrix (GSK)
HepB	Engerix-B (GSK); Recombivax HB (Merck)
HepA-HepB	Twinrix (GSK); can be given to teens age 18 and older
Hib	ActHIB (sanofi pasteur); Hiberix (GSK); PedvaxHIB (Merck)
Hib-HepB	Comvax (Merck)
IPV	Ipol (sanofi pasteur)
PCV13	Prevnar 13 (Pfizer)
PPSV23	Pneumovax 23 (Merck)
RV1	Rotarix (GSK)
RV5	RotaTeq (Merck)
Tdap	Adacel (sanofi pasteur); Boostrix (GSK)
Td	Decavac (sanofi pasteur), Generic (MA Biological Labs)

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Vaccine	Type of Vaccine[1]	Date given (mo/day/yr)	Funding Source (F,S,P)[2]	Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials & title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Measles, Mumps, Rubella[6] (e.g., MMR, MMRV) Give SC.[7]									
Varicella[6] (e.g., VAR, MMRV) Give SC.[7]									
Hepatitis A (HepA) Give IM.[7]									
Meningococcal (e.g., MCV4; MPSV4) Give MCV4 IM[7] and MPSV4 SC.[7]									
Human papillomavirus (e.g., HPV2, HPV4) Give IM.[7]									
Influenza (e.g., TIV, inactivated; LAIV, live attenuated) Give TIV IM.[7] Give LAIV IN.[7]									
Other									

See page 1 to record hepatitis B, diphtheria, tetanus, pertussis, *Haemophilus influenzae* type b, polio, pneumococcal, and rotavirus vaccines.

How to Complete this Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the site where vaccine was administered as either RA (right arm), LA (left arm), RT (right thigh), LT (left thigh), or IN (intranasal).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
6. For combination vaccines, fill in a row for each antigen in the combination.
7. IM is the abbreviation for intramuscular; SC is the abbreviation for subcutaneous; IN is the abbreviation for intranasal.

Abbreviation	Trade Name & Manufacturer
MMR	MMRII (Merck)
VAR	Varivax (Merck)
MMRV	ProQuad (Merck)
HepA	Havrix (GlaxoSmithKline [GSK]); Vaqta (Merck)
HepA-HepB	Twinrix (GSK)
HPV2	Cervarix (GSK)
HPV4	Gardasil (Merck)
LAIV (Live attenuated influenza vaccine]	FluMist (MedImmune)
TIV (Trivalent inactivated influenza vaccine)	Afluria (CSL Biotherapies); Agriflu (Novartis); Fluarix (GSK); FluLaval (GSK); Fluvirin (Novartis); Fluzone (sanofi)
MCV4	Menactra (sanofi pasteur); Menveo (Novartis)
MPSV4	Menomune (sanofi pasteur)

FOR THE PARENTS

To what extent is your child accustomed to being away from home?

Is he/she enthusiastic about attending camp?

What experience has your child had at a camp: Happy Unhappy Please explain:

With whom does your child live? ___________________________________

Is either parent deceased? No Yes

If yes, which parent, date of death and was death associated with your child's burn injury (such as a house fire in which others were injured or killed)?

Are parents separated or divorced?
Date__________________ Age of Camper when this happened___________________

Has your child had any special problems associated with academic performance or behavior? YES NO

If yes, please explain:

How can we be most helpful to your child at camp?

Does your child have: please circle

one special friend

difficulty making friends

not one particular friend but a large circle of acquaintances

a variety of friends

Have friendship patterns or interactions with peers changed since the burn injury? Please explain:

How would you describe your child's adjustment to his/her injury?

Has this changed since the burn injury?

Below, please CIRCLE the appropriate comments to indicate your general feeling about your child's personality.

Shy /timid angry self confident

Sad /withdrawn a leader among friends

Follower of others aggressive

Enthusiastic/happy

Cooperative /helpful

In addition, please share with us if your child is currently dealing with any special life issues such as divorce, a recent death, peer or school pressure, a learning disability, or alcohol, drug or cigarette use.

Is there anything else that you feel would be helpful for us to know about your child?

Has your child ever had professional counseling?

If so, approximate dates and duration of treatment: ________________________

Was counseling beneficial?____

Focus of treatment____

NON-BURN RELATED OPERATIONS AND/OR FRACTURES

Type______________________ Date____________________

Type______________________ Date____________________

Comments: ____

Does child have any of the following conditions: **Please Circle**

Bedwetting Diabetes Shortness of Breath Epilepsy Sleep walking Headaches Asthma

Allergies: Hay Fever Food Drug Other

If other is circled, list type and treatment:

Blood borne disease requiring specific precautions

List Precautions:

Has child been exposed to or had any infectious disease within the past four weeks? Yes No

If yes, explain: ____

Does child have dietary restrictions of which we should be aware? Yes No
If yes, explain:

Please list any specific dressing changes, frequency and/or specific types of dressings you would like to be done on your child.(Please send specialty dressings with the patient) General dressing supplies will be provided.

Please list any medications your child will require during their stay at camp. And indicate if we will need to provide any PT or OT session for your child.

Medication Dose Route

Times to be Given Reason

Does child presently wear pressure garments? Yes No

If yes, which garments are worn: ____

How many sets of garments will he or she bring to camp? ____________

Schedule for Use: ____

Does child presently wear splints or orthopedic devices? Yes No

If yes, please explain:

Does child presently receive Occupational Therapy? Yes No

If yes, frequency: ____

Name of OT: _______________________________________ Telephone ( ) ___________________

Does child presently receive Physical Therapy? Yes No If yes, frequency:

Name of Physical Therapist: ____________________________ Telephone ( ) ___________________

Does child have any physical limitations (ie: amputations, low endurance, recent surgeries, etc.) which may affect his or her participation in camp activities? Yes No

If yes, explain:

____

Thank you.

This information will help acquaint us with your child prior to camp and will assist us in providing a positive camping experience for him/her.

NOTE: If your child is currently or has previously received counseling or psychotherapy, a brief summary statement from his or her therapist indicating treatment issues as well as issues relevant to camp is REQUIRED as part of the application process. This need not be lengthy. Its intended use is to guide and assist us in providing for your child a camp experience that will build on counseling goals. Your therapist’s report can be included with the camp application material.

FOR THE CAMPER

Here are some statements. Please check the answer that suits you most:

YES
NO

I can talk openly to others about my burns.

When people on the street look at me, I feel uneasy.

I often think of the time I was in the hospital and it upsets me.

I try to think as little as possible about how I look.

I do not know what to say when asked about my scars.

I am just like all the other kids in my class.

I would like to be able to talk more about my burn scars.

What are the things that excite you about camp?

When you think about coming to camp, are there things that worry you?

What would you like to accomplish at Winter Camp?

Would you prefer to: Ski Snowboard Both

What skill level are you? Never Beginner Intermediate Advanced