



A program of The ELM Project

Camper Application 2024

Children with Sickle Cell & Siblings

This packet is to be filled out by parent/guardian

88 Hamilton Avenue • Stamford, CT 06902 Phone (203) 658-9577 • Fax (203) 658-9615

Today's Date: _____ Session Date: Sunday, August 18th – Saturday, August 24th

Camper's Name: _____ DOB: ____/____/____ Age: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Sex: Male Female Other If other, please explain: _____

Is child a: Returning camper OR new camper First time sleeping away from home? Yes No

Race/Ethnicity: _____ Primary language spoken at home: _____

Referring Hospital/Agency: _____

CHILD OR GUARDIAN'S SOCIAL WORKER/CASE MANAGER INFORMATION (IF APPLICABLE):

Name: _____ Phone: _____ Email: _____

GUARDIAN INFORMATION:

Name(s) of Child's Guardian(s): _____

Relationship to Child: Parent Grandparent Aunt/Uncle Foster Parent Adoptive Parent

Group Living Situation Other Relation? _____

Cell Phone: _____ Home Phone: _____

Email: _____

PLEASE FILL IN THE FOLLOWING ABOUT ALL MEMBERS OF THE HOUSEHOLD:

What is the total number of people in your household? _____

Name	Age	Sex	Relation	Lives at Home
		M <input type="checkbox"/> F <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
		M <input type="checkbox"/> F <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
		M <input type="checkbox"/> F <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
		M <input type="checkbox"/> F <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
		M <input type="checkbox"/> F <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
		M <input type="checkbox"/> F <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
		M <input type="checkbox"/> F <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

The mission of The ELM Project is to serve children infected with and/or affected by HIV/AIDS and sickle cell disease. Please tell us how your child relates to the mission: **(THIS QUESTION IS REQUIRED)**

CHILD'S MEDICAL INFORMATION:

	Sickle Cell Status			Is the person indicated living?		
	Disease	Trait	Negative	Yes	No	Unknown
Child applying to camp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Biological Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biological Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current Primary Caregiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

If your child **does not** have sickle cell disease, please **skip to the bottom of this page.**

If your child has sickle cell disease, please continue filling out this section:

Pain:

Please describe your child's typical pain episodes and location:

How often does your child have pain crisis? _____

What medicine does your child take for the following condition? (Indicate medication and dose)

Mild Pain: _____

Moderate (increasing) Pain: _____

Severe Pain: _____

What type of things help with your child's pain? (Hot shower? Sleep? Heating pads?)

Is there anything else we should know about your child's pain crisis? _____

Is there anything that might trigger a pain crisis? Example: emotional stress, changes in the environment, etc.

Hospitalizations:

Is your child frequently hospitalized? Yes No If Yes, how many times a year? _____

For how many days on average? _____ When was your child last in the hospital? Date: _____

For how long? _____ Why? _____

Has your child ever been in the intensive care unit? When and Why? _____

Has your child had any of the following complications? (check all that apply)

Acute Chest	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sleep Apnea	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Splenomegaly	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Blood Infection	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Gallstones/Cholecystitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hip Pain/Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Priapism	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Iron Overload	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

Other Comments: _____

Does your child require night-time oxygen supplementation? Yes No

Medical Information Continued (to be filled out for ALL campers) ...

Does your child have any dietary restrictions, weight loss or eating concerns? If so, please explain:

Does your child have any other medical conditions like: asthma, seizure disorders, cardiac disorders, etc.? If Yes, please explain:

Has your child ever been diagnosed with any psychiatric disorders? i.e., depression, anxiety, OCD, etc. Yes No

If yes, please provide details: _____

Has your child ever had thoughts of suicide, attempted suicide, or engaged in self-injury? If so, When?

Please explain: _____

Does your child sleepwalk? Yes No

Does your child have a history of bedwetting? Yes No

If necessary, please provide details on the above or on child's sleep habits: _____

Does child use/have (check all that apply): Home oxygen concentrator Wheelchair Hearing Aid
Walker/Crutches Splint/Brace Contact lenses Artificial limb Amputation Glasses Other: _____

If necessary, please provide details on the above _____

Does your child require assistance showering or dressing? Yes No

May your child participate in swimming**? Yes No Warm water only

****Please Note: Swimming at camp takes place under the supervision of highly trained lifeguards and instructors. No child is ever left unsupervised or alone in or near the water. **Also, the pool is heated for those children sensitive to cold temperatures.**

For Females ONLY:

Does your child get her menstrual period? Yes No

If yes, does she have any difficulties with her menstrual period? Yes No

If yes, please explain: _____

May your child use tampons if necessary? Yes No

SCHOOL INFORMATION:

Name of Your Child's School: _____

Grade during 2023-2024 school year: 1ST 2ND 3RD 4TH 5TH 6TH 7TH 8TH 9TH
10TH 11TH 12TH

Is your child in Special Education? Yes No

If yes, please provide a copy of your child's Individual Education Plan (IEP).

Do you or the school have concerns about your child's behavior in school? Yes No

If yes, please describe _____

Has your child ever been suspended from school? Yes No If yes, please explain the reason, when the suspension occurred and for how long: _____

Is your child receiving *counseling services*: in school: Yes No via a clinic or hospital? Yes No

When your child is angry, frustrated or upset how do they handle themselves? What is the best way to handle this behavior? _____

Have there been any recent deaths, losses or changes for the family or your child that might cause concerns or affect their behavior while at camp? _____

Please share anything else that you think is important for us to know about your child: _____

PARENT / GUARDIAN CONSENT FORM

****THIS FORM MUST BE SIGNED AT THE BOTTOM IN ORDER FOR YOUR CHILD TO ATTEND CAMP AMERIKIDS PROGRAMMING ****

CONSENT FOR MEDICAL TREATMENT

I, the undersigned parent/guardian hereby grant permission to the medical staff or consulting physician at Camp AmeriKids to administer medications and provide medical care for the attending camper. I also give consent for any emergency transportation deemed necessary. I understand that all attempts will be made to reach me or an emergency contact before any action is taken. If no contact is available, the decision to treat my child will be made by the camp Medical Director and Executive Director. I also understand that The ELM Project, Inc. will treat all information pertaining to my child as confidential; however, I agree that said information may be shared with/released to appropriate personnel and/or third parties for the purpose of treating and/or supervising my child.

ASSUMPTION OF RISK

I understand that part of the camping experience involves activities and group living arrangements and interactions that may be new to my child, and that they come with certain risks and uncertainties beyond what my child may be used to dealing with at home. These risks include but are not limited to, nature walks, uneven terrain, insects, interactive games, illnesses, and sports injuries. I am aware of these risks, and I am assuming them on behalf of my child. I realize that no environment is risk-free, and so I have instructed my child on the importance of abiding by the camp's rules, and my child and I both agree that they are familiar with these rules and will obey them.

JURISDICTIONAL CLAUSE

It is agreed that any dispute or cause of action arising between the parties, whether out of this agreement or otherwise, can only be brought in the Supreme and County Court of Sullivan County, New York, and shall be construed in accordance with the laws of New York.

CONSENT OF ENROLLMENT

I agree to enroll my child in Camp AmeriKids, a program of The ELM Project, Inc. I understand that by giving my consent, my child will be able to participate in all activities, including transportation to and from the campsite, provided by The ELM Project, Inc., unless otherwise noted on the application form. In addition, The ELM Project, Inc. is not responsible for personal property that is lost or stolen. The Executive Director in their sole discretion may dismiss a participant at any time and The ELM Project, Inc. is responsible for that child's transportation back home.

I fully understand and agree to the terms stated above and agree that all information on this application is complete and correct to the best of my knowledge.

Print Child's Name

Parent/Guardian Signature

Print Parent/Guardian Name

Date



COVID Informed Consent and Waiver

The ELM Project has put in place preventative measures to reduce the spread of COVID-19; however, we cannot guarantee that you, your household members, or your child(ren) will not become infected with COVID-19. Further, attending Camp AmeriKids programming could increase your risk and your child(ren)'s risk of contracting COVID-19. By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren), household members, and I may be exposed to or infected by COVID-19 by attending Camp AmeriKids and that such exposure or infection may result in personal injury, illness, permanent disability, and death.

I am aware of these risks, and I am assuming them on behalf of my child and my household. I realize that no environment is risk-free, and so I have instructed my child on the importance of abiding by the camp's rules and COVID protocols and my child and I both agree that they are familiar with these rules and will obey them.

On my behalf, and on behalf of my child, I hereby release, covenant not to sue, discharge, and hold harmless Camp AmeriKids, their employees, officials, agents, and representatives, of and from any claims, including all liabilities, claims, actions, damages, costs, or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of Camp AmeriKids programs, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation at Camp AmeriKids.

Please note that Camp AmeriKids strongly urges campers to be vaccinated for COVID-19. **While this is currently *not* a mandatory requirement for camp**, depending on how things may change over the next few months, our policy might change.

I understand that my signature below gives consent for my child to be tested for COVID prior to and/or while at camp, if deemed necessary by the Medical Director. I agree to enroll my child in Camp AmeriKids, a program of The ELM Project, Inc.

Print Child's Name

Parent/Guardian Signature

Print Parent/Guardian Name

Date

EMERGENCY CONTACT NUMBERS

****Please include contact information for *at least three (3)* individuals other than parent/guardian****

I authorize the following person(s) or agency to be contacted in the event of an emergency and I cannot be reached. I also authorize the following person(s) or agency to be contacted and authorize my child to be turned over to this person(s) if for any reason my child must leave camp or be picked-up at the bus stop if I am unavailable.

1. Name: _____ Relationship to child: _____
Cell Phone: _____ Home Phone: _____

2. Name: _____ Relationship to child: _____
Cell Phone: _____ Home Phone: _____

3. Name: _____ Relationship to child: _____
Cell Phone: _____ Home Phone: _____

Media Release Form 2024

*Note: The names of Camp AmeriKids campers **will not** be released*

I give The ELM Project, Inc. permission to photograph, interview and/or video tape my child and use pictures or videos of my child either alone or in groups to be used in promotional, fundraising, or educational materials including, but not limited to video tapes, slide shows, pamphlets, newsletters, calendars, website content and social media. I understand that The ELM Project will not release photographs or videos of my child to newspapers or television media without obtaining additional consent. I authorize The ELM Project, its assignees, and transferees to copyright, use and publish the previously mentioned materials in both print and electronic formats. I waive my rights to hold The ELM Project officers, staff, board members, or volunteers liable connected with the taking and use of the previously mentioned materials. In addition, I waive all rights, interests, or claims for payment in connections with any exhibition or release of these materials. **The ELM Project respects the privacy of its campers and their families and does not allow unauthorized visitors to photograph the camp or campers.** I hereby acknowledge that I have given this consent voluntarily to The ELM Project.

Print Child's Name

Parent/Guardian Signature

Print Parent/Guardian Name

Date

If you have questions or concerns regarding the media release of your child/ren please do not hesitate to call Nyeka at the office: 203.658.9577.



<p>To be filled out by parent/guardian</p>

HIPAA FORM

I, _____ (**GUARDIANS' NAME**), hereby authorize The ELM Project, Inc.'s Camp Physician to use or disclose my child's, _____ (**CAMPERS' NAME**), protected health information (as defined herein) to the Camp Director and other medical or pertinent staff as is deemed necessary by the Director or the Camp Physician for the safety and wellbeing of my child during the Camp AmeriKids program.

In addition, I authorize the Camp Physician to request, secure and use information regarding any prior and ongoing health condition and any prior and ongoing care and treatment from all health care providers holding such information (my "Protected Health Information") including, but not limited to: history and physical examination; admission and discharge summaries; operative reports; progress notes and nursing notes; laboratory reports; radiology reports; immunization records; billing summaries; consultation reports; pathology reports; psychological and psychiatric assessments; and medications.

I understand that in the event my child was treated for drug or alcohol abuse, psychiatric condition, communicable diseases, including HIV/AIDS, this information will be included as part of my Protected Health Information.

I understand that the Camp Physician may not condition treatment or eligibility to participate in the Camp AmeriKids program on my signing this authorization.

I understand that this authorization is intended for use or disclosure of my child's Protected Health Information to the extent of and as permitted by the Standards for Privacy of Individually Identifiable Health Information (the so-called "Privacy Rule") issued by the U.S. Department of Health and Human Services to implement the requirement of the Health Insurance Portability and Accounting Act of 1996 ("HIPAA"). I have been given an opportunity to inquire and request information to my satisfaction regarding the requirements of the above law and regulations.

I understand that this authorization will expire automatically on the later of 90 days from the date hereof or the end of the camp period, and I also understand that I may cancel and revoke this authorization at any time effective upon my delivering written notice thereof to the Camp Physician except to the extent there has already been use or disclosure in reliance on this authorization.

(Signature of legal Guardian)

Date

(Relationship of Legal Guardian to child)

Child's Social Security Number: _____

Child's Date of Birth: _____