



KIDS 'N' CANCER FAMILY CAMP

Philoptochos Camp Agape Northwest

July 26-31, 2010

PO BOX 65504

University Place, WA 98464

www.campagepenw.org

Dear Parent,

We are happy that you and your family are interested in attending Philoptochos Camp Agape Northwest. Camp Agape NW is provided at no cost for your child afflicted with cancer, their parents or legal guardians, and all siblings. Camp Agape NW campers and their siblings range in ages from infancy up to 18 years (and parents of any age). Camp Agape NW is open to families of all religious faiths and nationalities.

Camp Agape NW is open to families whose child receives cancer treatment in Washington State; whether the family resides within Washington or not. It is also open to families who have attended other family cancer camps. In the event that camp is full, priority acceptance will be given to families residing in Washington, to those who have not experienced another family cancer camp, and/or on severity of the child's diagnosis. Camp Agape fills up quickly and you are encouraged to apply as soon as possible. If you have any questions regarding who is eligible please contact us.

In this packet you will find forms for completion as well as general camp information. Application forms numbered 1-6 indicate that your family would like to attend Camp Agape NW on **July 26-31, 2010**. For the safety of our children, Camp Agape NW has made it policy to run background checks on every person, over age 18, who is on site during the week. This will apply to campers and volunteers. All information will be kept confidential. Your review is limited to offenses that indicate there may be potential harm to other campers. For this purpose, please fill out the included background form in addition. Completing these forms does not guarantee acceptance. You will be notified upon receipt of your application and of your acceptance status. Once your families' acceptance has been confirmed you and your family can prepare for camp! Form numbers 7 and 8 need to be completed and brought with you to camp. We cannot accept campers who arrive at camp with incomplete medical forms. **You must have a completed *Medical Evaluation Form* signed by a licensed practitioner. We do not have access to a fax machine at camp, and you must have your provider's permission to be able to attend camp.**

**For preferred acceptance please complete and return forms # 1-8 by May 16, 2010 to
Sofia Kenny Camp Agape NW Registration Chair
112 Howe St.
Seattle WA, 98109**

Application forms to mail now (if you need more room please write on the back or attach additional sheets)

1. Application Form
2. Parents/Guardians' medical information
3. Camper's medical information
4. Siblings' medical information
5. Authorization for disclosure
6. Consent For medical treatment
7. Background check forms for each family member age 18 and over
8. Tee-Shirt Order Form (provided free of charge)

Forms 9-10 need to be completed and brought with you to camp

9. Camper Medical Evaluation form (must be completed by health care professional)
10. Family medication list form

If you have any questions please contact:

Sofia Kenny
Philoptochos Camp Agape NW Registration Chair
206-285-7144
Sofia710@gmail.com

Mindi Chouinard RN, BSN, OCN
Camp Agape NW Head Nurse
253-376-5005
melindac40@comcast.net

START: This is the beginning of the application forms that need to be returned by mail.

CAMPER AND FAMILY MEMBERS WHO WOULD LIKE TO ATTEND CAMP AGAPE NW:

Please attach additional sheets if necessary

| | | |
|---|---------------|------|
| Family Name: | | |
| Street Address: | | |
| City: | State; | Zip: |
| Best Number to reach you: | Mobile Phone: | |
| E-mail: | E-mail: | |
| How did you learn about Camp Agape NW? | | |
| Why does your family want to attend Camp Agape NW? | | |
| Has your family attended other family camps? If yes, please list names and dates: | | |
| Anything else relevant that we should consider or know when reviewing your application? | | |

| | | |
|--------------------|---|---------------|
| ADULTS: | | |
| First / Last Name: | Male <input type="checkbox"/> Female <input type="checkbox"/> | Relationship: |
| First / Last Name: | Male <input type="checkbox"/> Female <input type="checkbox"/> | Relationship: |

| | | |
|-----------------------------------|-------------------------------|---------------------------------|
| CAMPER/ CHILD WITH CANCER: | | |
| First and Last Name: | Male <input type="checkbox"/> | Female <input type="checkbox"/> |
| Birthdate: | | |
| Camper Diagnosis | Date diagnosed: | |

| | | |
|--------------------|---|------------|
| SIBLINGS: | | |
| First / Last Name: | Male <input type="checkbox"/> Female <input type="checkbox"/> | Birthdate: |
| First / Last Name: | Male <input type="checkbox"/> Female <input type="checkbox"/> | Birthdate: |
| First / Last Name: | Male <input type="checkbox"/> Female <input type="checkbox"/> | Birthdate: |

(if more please complete on back)

Signature of Parent/Legal Guardian _____ Date: _____

| | | | |
|--|--|---|--|
| PARENT OR GUARDIAN #1 First / Middle initial/ Last Name: | | | |
| Birthdate MM/DD/YYYY: | | Male <input type="checkbox"/> Female <input type="checkbox"/> | |
| Health Insurance: | | Name of policy holder: | |
| Policy # | | Group # | |
| Physician Name: | | Physician Phone #: | |
| In case of emergency contact name: | | relationship: | |
| phone number: | | alternative phone number: | |
| Medical Conditions: | | Medical Conditions: | |
| Explain/ include dates: | | Explain/ include dates: | |
| Chicken Pox <input type="checkbox"/> | | High Blood Pressure <input type="checkbox"/> | |
| Measles <input type="checkbox"/> | | Kidney Problems <input type="checkbox"/> | |
| Mumps <input type="checkbox"/> | | Liver Problems <input type="checkbox"/> | |
| Shingles <input type="checkbox"/> | | Bowel Problems <input type="checkbox"/> | |
| Seizures (Type) <input type="checkbox"/> | | Eye Problems <input type="checkbox"/> | |
| Diabetes <input type="checkbox"/> | | Hearing Problems <input type="checkbox"/> | |
| Heart Problems <input type="checkbox"/> | | Asthma <input type="checkbox"/> | |
| Bleeding Disorders <input type="checkbox"/> | | Ear Infection <input type="checkbox"/> | |
| Clotting Disorders <input type="checkbox"/> | | Other <input type="checkbox"/> | |
| Surgeries or hospitalizations: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Recent Exposure to Infection? None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Physical/ mental disabilities or any special needs: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Other Comments or Limitations: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Prescription, over the counter, or herbal medications: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Allergies: | | Type of Reaction: | |
| Hay fever | | | |
| Insects/Bees | | | |
| Food Allergies | | | |
| Medications | | | |
| Other: | | | |
| Immunization History: | | Date of Booster: | |
| DPT | | Polio: | |
| Pertussis | | Chicken Pox: | |
| Measles, Mumps, Rubella | | Other: | |

| | | | |
|--|-------------------------|---|-------------------------|
| PARENT OR GUARDIAN #2 First / Middle initial/ Last Name: | | | |
| Birthdate MM/DD/YYYY: | | Male <input type="checkbox"/> Female <input type="checkbox"/> | |
| Health Insurance: | | Name of policy holder: | |
| Policy # | | Group # | |
| Physician Name: | | Physician Phone #: | |
| In case of emergency contact name: | | relationship: | |
| phone number: | | Alternative phone number: | |
| Medical Conditions: | | Medical Conditions: | |
| Explain/ include dates: | | Explain/ include dates: | |
| Chicken Pox <input type="checkbox"/> | | High Blood Pressure <input type="checkbox"/> | |
| Measles <input type="checkbox"/> | | Kidney Problems <input type="checkbox"/> | |
| Mumps <input type="checkbox"/> | | Liver Problems <input type="checkbox"/> | |
| Shingles <input type="checkbox"/> | | Bowel Problems <input type="checkbox"/> | |
| Seizures (Type) <input type="checkbox"/> | | Eye Problems <input type="checkbox"/> | |
| Diabetes <input type="checkbox"/> | | Hearing Problems <input type="checkbox"/> | |
| Heart Problems <input type="checkbox"/> | | Asthma <input type="checkbox"/> | |
| Bleeding Disorders <input type="checkbox"/> | | Ear Infection <input type="checkbox"/> | |
| Clotting Disorders <input type="checkbox"/> | | Other <input type="checkbox"/> | |
| Surgeries or hospitalizations: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Recent Exposure to Infection? None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Physical/ mental disabilities or any special needs: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Other Comments or Limitations: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Prescription, over the counter, or herbal medications: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Allergies: | | Type of Reaction: | |
| Hay fever | | | |
| Insects/Bees | | | |
| Food Allergies | | | |
| Medications | | | |
| Other: | | | |
| Immunization History: | Date of Booster: | Immunization | Date of Booster: |
| DPT | | Polio: | |
| Pertussis | | Chicken Pox: | |
| Measles, Mumps, Rubella | | Other: | |

| | | | |
|--|--------------------------------|--|---------------------------------|
| Child # 1: Camper Medical Form: | | | |
| First / Middle initial/ Last Name: | | | |
| Birthdate MM/DD/YYYY: | | Male <input type="checkbox"/> | Female <input type="checkbox"/> |
| Health Insurance: | | Name of policy holder: | |
| Policy # | | Group # | |
| Physician Name: | | Physician Phone #: | |
| Cancer Diagnosis | | Date diagnosed: | |
| Camper's status (check all that apply): remission <input type="checkbox"/> relapse <input type="checkbox"/> actively in treatment <input type="checkbox"/> terminal <input type="checkbox"/> unknown <input type="checkbox"/> | | | |
| Do you anticipate low blood counts during the week of camp? Yes: <input type="checkbox"/> No: <input type="checkbox"/> Explain: | | | |
| Special Diet? Yes: <input type="checkbox"/> No: <input type="checkbox"/> Explain: | | | |
| Central Line? Yes: <input type="checkbox"/> No: <input type="checkbox"/> Type: | | | |
| Medical Conditions: | Explain/ include dates: | Medical Conditions: | Explain/ include dates: |
| Chicken Pox <input type="checkbox"/> | | High Blood Pressure <input type="checkbox"/> | |
| Measles <input type="checkbox"/> | | Kidney Problems <input type="checkbox"/> | |
| Mumps <input type="checkbox"/> | | Liver Problems <input type="checkbox"/> | |
| Shingles <input type="checkbox"/> | | Bowel Problems <input type="checkbox"/> | |
| Seizures (Type) <input type="checkbox"/> | | Eye Problems <input type="checkbox"/> | |
| Diabetes <input type="checkbox"/> | | Hearing Problems <input type="checkbox"/> | |
| Heart Problems <input type="checkbox"/> | | Asthma <input type="checkbox"/> | |
| Bleeding Disorders <input type="checkbox"/> | | Ear Infection <input type="checkbox"/> | |
| Clotting Disorders <input type="checkbox"/> | | Other <input type="checkbox"/> | |
| Surgeries or hospitalizations: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Recent Exposure to Infection? None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Physical/ mental disabilities or any special needs: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Other Comments or Limitations: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Prescription, over the counter, or herbal medications: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Allergies: | Type of Reaction: | | |
| Hay fever | | | |
| Insects/Bees | | | |
| Food Allergies | | | |
| Medications | | | |
| Other: | | | |
| Immunization History: | Date of Booster: | Immunization | Date of Booster: |
| DPT | | Polio: | |
| Pertussis | | Chicken Pox: | |
| Measles, Mumps, Rubella | | Other: | |
| This child is: high energy <input type="checkbox"/> moderate energy <input type="checkbox"/> low energy <input type="checkbox"/> other explain: | | | |
| What does this child like to do for fun? | | | |
| What hobbies does your child enjoy? | | | |
| Anything else about your child we should know? | | | |

| | | | |
|---|--------------------------------|--|---------------------------------|
| Child #2 Sibling Medical Form: | | | |
| First / Middle initial/ Last Name: | | | |
| Birthdate MM/DD/YYYY: | | Male <input type="checkbox"/> | Female <input type="checkbox"/> |
| Physician Name: | | Physician Phone #: | |
| Health Insurance: | | Name of policy holder: | |
| Policy # | | Group # | |
| Medical Conditions: | Explain/ include dates: | Medical Conditions: | Explain/ include dates: |
| Chicken Pox <input type="checkbox"/> | | High Blood Pressure <input type="checkbox"/> | |
| Measles <input type="checkbox"/> | | Kidney Problems <input type="checkbox"/> | |
| Mumps <input type="checkbox"/> | | Liver Problems <input type="checkbox"/> | |
| Shingles <input type="checkbox"/> | | Bowel Problems <input type="checkbox"/> | |
| Seizures (Type) <input type="checkbox"/> | | Eye Problems <input type="checkbox"/> | |
| Diabetes <input type="checkbox"/> | | Hearing Problems <input type="checkbox"/> | |
| Heart Problems <input type="checkbox"/> | | Asthma <input type="checkbox"/> | |
| Bleeding Disorders <input type="checkbox"/> | | Ear Infection <input type="checkbox"/> | |
| Clotting Disorders <input type="checkbox"/> | | Other <input type="checkbox"/> | |
| Surgeries or hospitalizations: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Recent Exposure to Infection? None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Physical/ mental disabilities or any special needs: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Other Comments or Limitations: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Prescription, over the counter, or herbal medications: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Allergies: | Type of Reaction: | | |
| Hay fever | | | |
| Insects/Bees | | | |
| Food Allergies | | | |
| Medications | | | |
| Other: | | | |
| Immunization History: | Date of Booster: | Immunization | Date of Booster: |
| DPT | | Polio: | |
| Pertussis | | Chicken Pox: | |
| Measles, Mumps, Rubella | | Other: | |
| This child is: high energy <input type="checkbox"/> moderate energy <input type="checkbox"/> low energy <input type="checkbox"/> other explain: | | | |
| What does this child like to do for fun? | | | |
| What hobbies does your child enjoy? | | | |
| Anything else about your child we should know? | | | |

| | | | |
|---|--|---|--|
| Child #3 Sibling Medical Form: | | | |
| First / Middle initial/ Last Name: | | | |
| Birthdate MM/DD/YYYY: | | Male <input type="checkbox"/> Female <input type="checkbox"/> | |
| Physician Name: | | Physician Phone #: | |
| Health Insurance: | | Name of policy holder: | |
| Policy # | | Group # | |
| Medical Conditions: | | Explain/ include dates: | |
| Chicken Pox <input type="checkbox"/> | | High Blood Pressure <input type="checkbox"/> | |
| Measles <input type="checkbox"/> | | Kidney Problems <input type="checkbox"/> | |
| Mumps <input type="checkbox"/> | | Liver Problems <input type="checkbox"/> | |
| Shingles <input type="checkbox"/> | | Bowel Problems <input type="checkbox"/> | |
| Seizures (Type) <input type="checkbox"/> | | Eye Problems <input type="checkbox"/> | |
| Diabetes <input type="checkbox"/> | | Hearing Problems <input type="checkbox"/> | |
| Heart Problems <input type="checkbox"/> | | Asthma <input type="checkbox"/> | |
| Bleeding Disorders <input type="checkbox"/> | | Ear Infection <input type="checkbox"/> | |
| Clotting Disorders <input type="checkbox"/> | | Other <input type="checkbox"/> | |
| Surgeries or hospitalizations: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Recent Exposure to Infection? None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Physical/ mental disabilities or any special needs: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Other Comments or Limitations: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Prescription, over the counter, or herbal medications: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Allergies: | | Type of Reaction: | |
| Hay fever | | | |
| Insects/Bees | | | |
| Food Allergies | | | |
| Medications | | | |
| Other: | | | |
| Immunization History: | | Date of Booster: | |
| DPT | | Polio: | |
| Pertussis | | Chicken Pox: | |
| Measles, Mumps, Rubella | | Other: | |
| This child is: high energy <input type="checkbox"/> moderate energy <input type="checkbox"/> low energy <input type="checkbox"/> other explain: | | | |
| What does this child like to do for fun? | | | |
| What hobbies does your child enjoy? | | | |
| Anything else about your child we should know? | | | |

| | | | |
|---|-------------------------|---|-------------------------|
| Child #4* Sibling Medical Form: | | | |
| First / Middle initial/ Last Name: | | | |
| Birthdate MM/DD/YYYY: | | Male <input type="checkbox"/> Female <input type="checkbox"/> | |
| Physician Name: | | Physician Phone #: | |
| Health Insurance: | | Name of policy holder: | |
| Policy # | | Group # | |
| Medical Conditions: | | Explain/ include dates: | |
| Chicken Pox <input type="checkbox"/> | | High Blood Pressure <input type="checkbox"/> | |
| Measles <input type="checkbox"/> | | Kidney Problems <input type="checkbox"/> | |
| Mumps <input type="checkbox"/> | | Liver Problems <input type="checkbox"/> | |
| Shingles <input type="checkbox"/> | | Bowel Problems <input type="checkbox"/> | |
| Seizures (Type) <input type="checkbox"/> | | Eye Problems <input type="checkbox"/> | |
| Diabetes <input type="checkbox"/> | | Hearing Problems <input type="checkbox"/> | |
| Heart Problems <input type="checkbox"/> | | Asthma <input type="checkbox"/> | |
| Bleeding Disorders <input type="checkbox"/> | | Ear Infection <input type="checkbox"/> | |
| Clotting Disorders <input type="checkbox"/> | | Other <input type="checkbox"/> | |
| Surgeries or hospitalizations: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Recent Exposure to Infection? None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Physical/ mental disabilities or any special needs: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Other Comments or Limitations: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Prescription, over the counter, or herbal medications: None <input type="checkbox"/> / Yes <input type="checkbox"/> Explain: | | | |
| Allergies: | | Type of Reaction: | |
| Hay fever | | | |
| Insects/Bees | | | |
| Food Allergies | | | |
| Medications | | | |
| Other: | | | |
| Immunization History: | Date of Booster: | Immunization | Date of Booster: |
| DPT | | Polio: | |
| Pertussis | | Chicken Pox: | |
| Measles, Mumps, Rubella | | Other: | |
| This child is: high energy <input type="checkbox"/> moderate energy <input type="checkbox"/> low energy <input type="checkbox"/> other explain: | | | |
| What does this child like to do for fun? | | | |
| What hobbies does your child enjoy? | | | |
| Anything else about your child we should know? | | | |

***If you have more than 4 children please print off extra sheets and attach one sheet per child.**

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PUBLICITY

As the parent or guardian of the minor child(ren) identified below, I give my consent for Camp Agape Northwest to use or disclose protected health information for publicity, which may include: newspaper, magazine, radio, videotape, Web sites, and other published material.

Information to be used or disclosed:

I authorize the use of my child(ren)'s name, age, sex, date of admission and discharge, city of residence, general nature of injury/illness, condition, treatment and prognosis, if applicable, and voice and image in photograph or video, for treatment period which began _____.

Please withhold the following information: _____

Information may be used by or disclosed to:

Please check box(es) that apply:

- Media agencies or organizations (such as TV, radio and newspapers)
- Camp Agape Northwest
- Other _____

I understand that once Camp Agape Northwest discloses this information and/or material, the person or organization that receives it may re-disclose it, and privacy laws may no longer protect it.

Please check one box:

- This authorization expires when Camp Agape Northwest no longer maintains or stores this material.
- This authorization expires on _____ (Date or Event).

I can revoke this authorization by notifying Camp Agape Northwest in writing at the address on the bottom of the page. If I do revoke the authorization, it won't affect any actions that Camp Agape Northwest has already taken based on this form. I understand that I don't have to sign this form for my child to get treatment from Camp Agape Northwest. By signing this form, I acknowledge that I have read and agreed to its terms.

THIS FORM DOES NOT AUTHORIZE THE DISCLOSURE OF WRITTEN OR PRINTED MEDICAL RECORDS

Signature: _____

Date: _____

Printed Name: _____

Phone Number: _____

Patient Name: _____

Email Address: _____

Sibling Name(s): _____

Address: _____

*Witness: _____

PHOTOGRAPHIC/VIDEO IMAGE RELEASE

I hereby give Camp Agape Northwest and its affiliates the absolute and irrevocable right and permission to take, use, re-use, publish, and re-publish photographic and video images of _____ (First and Last Name/s), in whole or in part, individually or in conjunction with other photographs, in any medium for publicity purposes, including without limitation, for purposes of illustration, promotion, advertising and trade.

This authorization and release shall also inure to the benefit of the legal representatives, licensees, and assigns of the parties.

Signature of Parent or Guardian

Date

Signature of Witness

Date



CONSENT FOR MEDICAL TREATMENT

Please attach additional sheets if necessary

Note to parents/guardian: The staff at Philoptochos Camp Agape Northwest desires the camp experience to be safe and healthy for all participants. In the event of illness or accident every attempt will be made for the parent/guardian to be able to make all medical decisions. However, in the event of emergency in the absence of parent/guardian, Camp Agape staff will obtain medical attention for the child until the parent/guardian can be reached:

Authorization of Treatment: I (print first and last name) _____, as the legal parent/guardian hereby give my permission for my child/children, as listed, to engage in all prescribed camp activities, except as noted. I grant permission to the nurse personnel selected by the camp to obtain any necessary medical treatment in my absence.

Child/Children's First and Last Names:

| |
|----|
| 1. |
| 2. |
| 3. |
| 4. |

As our attendance at Camp Agape is a privilege, I release Philoptochos Camp Agape Northwest, including its trustees, employees and agents, from my/or any member of my family's physical injury, including death or illness while at camp, including any camp sponsored travel to and from camp, in consideration of this privilege.

If ANY child attending camp with your family that is not in your legal guardianship a separate release must be signed and included in this packet.

Signature of parent/guardian

_____ Date _____

On the following pages you will find two Washington State background forms. If you have more than one family member age 18 or over, please make additional copies of the forms. If you are not a Washington state resident. Please contact Camp Agape NW and we will advise you on getting a background check. We cannot accept internet copies of background checks. Thank you for your cooperation to insure the safety of all our campers.

CRIMINAL HISTORY FOR **WASHINGTON RESIDENTS ONLY**

*****If you not from the state of Washington, you must have a background check done and sent to us directly from your state. You may not send it to us yourself*****

Have you been accused of a crime including, but not limited to abuse, neglect, any sexual offense, assault, mistreatment, or molestation of children and/or adults? Yes No

If yes, provide a full description including convictions, dates, and circumstances.

Have you been convicted of a felony? If yes, please explain:

Have you had any findings made against you in any civil adjudicative proceeding? If yes, please explain:

Have you had both convictions and findings made against you? If yes, please explain:

Do you have an individual living with you that has been convicted of a felony or accused of a crime including, but not limited to abuse, neglect, any sexual offense, assault, mistreatment, or molestation of children and/or adults? If yes, please explain:

Are there any other facts of circumstances in your background or current situation, which would compromise you being trusted with the care of young people? If yes, please explain:

REQUEST FOR CONVICTION CRIMINAL HISTORY RECORD

To preserve the safety of Camp Agape and participants, we run background checks on all volunteers.

| | | | |
|---|-----|-------------------|--|
| Applicant's Name First Middle Name Last | | | Drivers License # and State License # State |
| Date of Birth: ____ / ____ / ____ Month/Day/Year | | | List all other maiden or alias names: |
| Race | Sex | Social Security # | |

Any falsification, misrepresentation, or incompleteness in this disclosure is alone grounds for disqualification or termination. The information that I have provided may be verified, if necessary, by contacting persons or organizations named in this application. I hereby authorize contact of references and authorize Philoptochos Camp Agape NW to conduct a background check. If accepted, I will abide by the standards set forth by Philoptochos Camp Agape NW.

I, _____, attest that the above statements are true and complete to the best of my knowledge.

X

Signature of Participant

Date

CRIMINAL HISTORY FOR **WASHINGTON RESIDENTS ONLY**

*****If you not from the state of Washington, you must have a background check done and sent to us directly from your state. You may not send it to us yourself*****

Have you been accused of a crime including, but not limited to abuse, neglect, any sexual offense, assault, mistreatment, or molestation of children and/or adults? Yes No

If yes, provide a full description including convictions, dates, and circumstances.

Have you been convicted of a felony? If yes, please explain:

Have you had any findings made against you in any civil adjudicative proceeding? If yes, please explain:

Have you had both convictions and findings made against you? If yes, please explain:

Do you have an individual living with you that has been convicted of a felony or accused of a crime including, but not limited to abuse, neglect, any sexual offense, assault, mistreatment, or molestation of children and/or adults? If yes, please explain:

Are there any other facts of circumstances in your background or current situation, which would compromise you being trusted with the care of young people? If yes, please explain:

REQUEST FOR CONVICTION CRIMINAL HISTORY RECORD

To preserve the safety of Camp Agape and participants, we run background checks on all volunteers.

| | | | |
|--|-----|-------------------|---|
| Applicant's Name First Middle Name Last | | | Drivers License # and State <i>License # State</i> |
| Date of Birth: _____ / _____ / _____ Month/Day/Year | | | List all other maiden or alias names: |
| Race | Sex | Social Security # | |

Any falsification, misrepresentation, or incompleteness in this disclosure is alone grounds for disqualification or termination. The information that I have provided may be verified, if necessary, by contacting persons or organizations named in this application. I hereby authorize contact of references and authorize Philoptochos Camp Agape NW to conduct a background check. If accepted, I will abide by the standards set forth by Philoptochos Camp Agape NW.

I, _____, attest that the above statements are true and complete to the best of my knowledge.

X

Signature of Participant

Date

Every Family Member who attends camp will be given a Camp Agape NW T-shirt.
Please provide the following information.

Family name _____

| ADULTS: | |
|--------------------|---------------|
| First / Last Name: | T-Shirt Size: |
| First / Last Name: | T-Shirt Size: |

| Children: | |
|--------------------|---------------|
| First / Last Name: | T-Shirt Size: |
| First / Last Name: | T-Shirt Size: |
| First / Last Name: | T-Shirt Size: |

Available sizes are Adult: S, M, L, XL, 2XL
Youth: S, M, L

STOP! This is the end of the application forms that need to be returned by mail.



*Camp Information Sheet #1
(Keep for your information)*

Camp Guidelines

We are happy that you and your family are planning to attend Camp Agape Northwest. We want to ensure this experience is wonderful for all campers. To achieve this goal we need your help. The following guidelines are regarding the health and medical needs of the camper, as well as, any siblings or other family members who may attend.

For any child who will need medications or who will be currently on cancer therapy:

Please bring the following to the registration desk when checking in:

1. Completed Camper Lab Update Form (this is in addition to the registration forms and medical history forms that must be turned in prior to arriving at camp). Please note that we need a record of recent blood counts if your child has received chemotherapy or radiation one month prior to attending camp.
2. All medications needed for the week including over the counter medications. Medications should be labeled with your child's name and include directions for administration. **No medications are allowed in the campers' cabins.** Camp healthcare staff will store all medications and parents will administer medications. Refrigeration is available.
3. Bring supplies for central line (Hickman, Ports).
4. Any child, who needs counts, should have arrangements made prior to coming to camp. We do not arrange for draws and providers are not available to interpret results

For "on-treatment" campers:

In order for camp to be fun and meaningful, we expect that all campers will have a reasonable ability to fight infection, be able to manage normal bumps and scrapes. If your child has recently received treatment and there is a possibility of compromise, we must be aware of this. The minimum blood counts required to attend camp are ANC (absolute neutrophil count) of 1,000, platelet count of 100,000, and a HCT (hematocrit) of 25. Again, for campers who will have received chemotherapy or radiation one month prior to attending camp we must have these blood counts. **Your child should meet the minimum requirements in order to attend camp.**

For all campers:

We want to keep our campers healthy therefore we must be very strict with regard to communicable diseases. Anyone with symptoms of a contagious illness including fever, sore throat, earache, persistent cough, and/or runny nose should not come to camp. If you have questions please contact the head nurse Mindi Chouinard @ 253-376-5005. It may be possible to make arrangements to come later in the week. If anyone in the family has been exposed to chicken pox or Hepatitis A four weeks prior to camp the entire family will not be able to attend Camp Agape. Chicken Pox and Hepatitis present significant risk and we simply cannot afford exposing our campers. In addition, we will be screening all camp attendees for H1N1 symptoms again this year.

We do not wish to heighten anxiety, but rather provide a safe environment for all campers. If you have any questions, please contact your child's physician. If your child is unable to attend camp for any reason, please contact the Camp Agape Registration office immediately.

Sincerely,
Camp Agape Registration and Medical Staff



*Camp Information Sheet #2
(keep for your information)*

Guidelines for the Week of Camp

Camp Agape Northwest has established the following guidelines. These guidelines will provide an atmosphere of enjoyment and security. Please review them prior to arrival. The guidelines will also be posted in the camp cabins.

1. Campers (children) must be in the care of parents or staff at all times.
2. Campers and staff must stay within the designated camp area at all times unless previously arranged. All campers and staff must stay on the trails when walking through the campsite.
3. All medications must be turned in to the Camp Medical Center in St. George Cabin upon arrival at the camp. These will be available to the administering adult at any time.
4. All first aid is to be reported to the nursing staff.
5. Smoking is not allowed in any of the camp areas. Smoking is allowed off Camp grounds.
6. Any breakage of equipment, materials, or camp property is to be reported immediately to the Camp Director.
7. Cars are to be parked in the designated area. No available utility hook-up for campers and trailers.
8. Use of motor vehicles during the Camp is limited to entering or leaving the camp itself.
9. Telephone is available on campus for **emergency** use: **Camp Agape Northwest: (253) 265-6161.**
10. Pets are not allowed.
11. Waterfront and dock facilities only available during supervised activities.
12. Cabins are shared with other families and will be assigned upon the arrival of the families. Parents are able to request their roommates. Some cabins have attached restrooms while other cabins share the central shower house. Those with a medical necessity will be assigned the cabins with restrooms. Please contact us if you have questions or concerns.
13. Families or staff will not have access to a washer or dryer for personal laundry while at camp, so please plan accordingly.
14. All food and snacks will be provided. If you have special diets please notify Camp Agape prior to camp. With notice before camp, we can provide food to accommodate special diets. In addition, families are able to bring specialty foods.
15. No alcoholic beverages will be brought into Camp Agape Northwest.



Camp Information Sheet #3
(keep for your information)

Packing List

The following list has been prepared for your convenience in planning for your time at camp. Remember that old clothes are great camp clothes. It is not necessary to buy new items for camp. If there is anything you need for camp and do not have please set us know. Please write your name on the items that you bring.

_____ Warm sleeping bag and pillow

_____ Heavy sweaters and/or jacket (Evenings and mornings can be cool)

_____ Pants, jeans and shorts

_____ Two pair of shoes, a pair that can be worn in the water, and tennis shoes for active events

_____ T-shirts, sweatshirts, including long sleeve shirts for cool weather and hats

_____ Bath towel and beach towel, washcloths, swimsuits

_____ Toiletries (toothpaste, toothbrush, soap, comb etc) and a carrying bag

_____ Sun screen

_____ Insect repellent

_____ Flashlight and batteries

_____ Casual dress for parents for a special dinner

_____ Do not pack medications in luggage. All medications are to be given to the camp nursing staff at the time of registration.

OPTIONAL

_____ Laundry bag

_____ Camera and batteries/film

_____ Sunglasses

_____ Raincoat and windbreaker

_____ Books for rest time

_____ Chap-stick

_____ Fishing gear



Info Sheet #4 Map and Directions (keep for your information)

Camp Agape is held at All Saints Center
 205 Raft Island Drive East
 Gig Harbor, WA 98335
 Campus Phone: 253-265-6161

Please Note
 "Mapquest" and
 GPS devices are
 often unreliable in
 providing
 directions to All
 Saints Center.

DIRECTIONS TO ALL SAINTS CENTER
 (Distance from downtown Seattle: 49 miles)

South on Interstate 5 (I-5) to Exit 132.

West on Highway 16 (Bremerton) through Tacoma and across Narrows Bridge.

Take second Gig Harbor (Rosedale) exit, approximately 3.4 miles from Narrows Bridge also marked as "City Center."

At traffic light, continue straight onto Stinson Ave for approximately 1/2 mile to stop sign which is Rosedale St., and turn left.

Proceed for almost 3 miles to Ray Nash Dr., turn left and continue 0.7 miles to small grocery store.

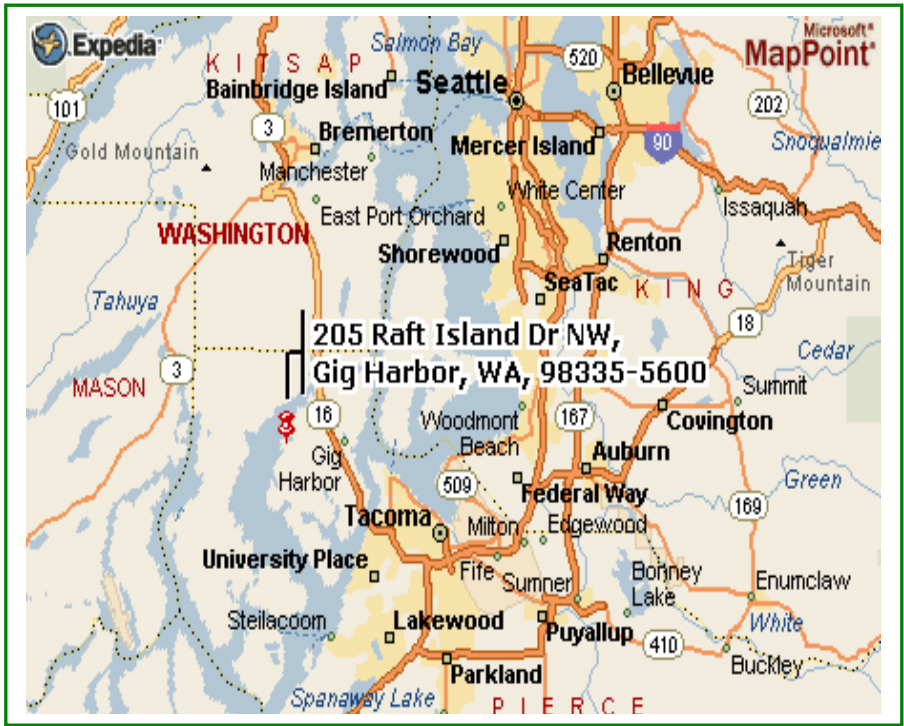
At store, continue straight ahead 1/2 mile on Kopachuck Dr. to "Raft Island" sign, then turn right.

Cross bridge and keep to the right at each "Y" in the road.

Hint: Just follow all signs to Kopachuck State Park from Highway 16 until the small grocery store.

The Ferry can be a fun and relaxing alternative to driving. The Fauntleroy – Southworth Route is one convenient choice. For more information please see the Washington State Ferries website at www.wsdot.wa.gov/ferries

Or call the Washington State Ferries at
 1-888-808-7977
 Or by dialing 5-1-1





Form # 9 Camper Medical Evaluation Form (Bring with you to camp)

Camp Agape NW Camper Medical Evaluation Form

Must be completed by health care professional

| | | | |
|--|---------|-----|--------|
| First and Last Name of Camper: | | | |
| Height: | Weight: | BP: | Pulse: |
| Diagnosis: | | | |
| Current treatment regimen: | | | |
| Chemotherapy name(s): | | | |
| Date of most recent Chemotherapy treatment: | | | |
| Date of most recent Radiation treatment: | | | |
| Sites Treated: | | | |
| Activity restrictions: | | | |
| Special precautions/considerations and any additional comments that would help us care for the camper: | | | |

Lab data: Please note if chemo or radiation was received in the month prior to attending camp he/she must complete a CBC within one week before camp begins.

| | |
|---------------------------|------------|
| Date of most recent draw: | |
| HCT: | ANC: |
| WBC: | % Bands: |
| % polys (segs): | Platelets: |

Review of Systems:

| | | | |
|------------------------|---|-----------------------------------|-----------|
| Growth/Development: | Within Normal Limits <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Describe: |
| Vision: | Within Normal Limits <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Describe: |
| Hearing: | Within Normal Limits <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Describe: |
| Mouth/Teeth: | Within Normal Limits <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Describe: |
| Cardiac: | Within Normal Limits <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Describe: |
| Respiratory: | Within Normal Limits <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Describe: |
| Abdominal/GI | Within Normal Limits <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Describe: |
| GU: | Within Normal Limits <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Describe: |
| Musculoskeletal: | Within Normal Limits <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Describe: |
| Skin: | Within Normal Limits <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Describe: |
| Neurological: | Within Normal Limits <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Describe: |
| Behavioral: | Within Normal Limits <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Describe: |
| Other, please specify: | | | Describe: |

| |
|--|
| Printed Name of Health Care Professional: |
| Phone Number of Health Care Professional: |
| Address of Health Care Professional: |
| Signature of Health Care Professional authorizing patient to attend Camp Agape NW: X _____ Date _____ |

