

# Trillium Childhood Cancer Support Centre Child Camper Health Record 2011/12

Please Print

(In effect for one year from date completed)



Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle mm/dd/yy

Home address \_\_\_\_\_  
Street Apt City Province Postal Code

Telephone (\_\_\_\_\_) \_\_\_\_\_ Sex  Male  Female Language  English  French  Other \_\_\_\_\_

Family Names Patient's Last Name \_\_\_\_\_ Other Family Member Last Names \_\_\_\_\_

Parent /Guardian Name \_\_\_\_\_  Mother  Father  \_\_\_\_\_

Address  lives with camper or \_\_\_\_\_  
Street Apt City Province Postal Code

Home telephone (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

Parent /Guardian Name \_\_\_\_\_  Mother  Father  \_\_\_\_\_

Address  lives with camper or \_\_\_\_\_  
Street Apt City Province Postal Code

Home telephone (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

If parent /guardian not available in an emergency, notify \_\_\_\_\_

Relation to camper \_\_\_\_\_ Home (\_\_\_\_\_) \_\_\_\_\_ Other (\_\_\_\_\_) \_\_\_\_\_

For valuable consideration, Camp Trillium allowing my/our child to participate in its activities, I/we \_\_\_\_\_ (legal guardian/parent) the \_\_\_\_\_ (enter the relationship to the child parent/legal guardian) of \_\_\_\_\_ (child) agree to the following:

In order to enhance experiences and provide a safe environment, all persons attending Trillium programs are asked to provide certain medical and social information. This information may be shared with the Trillium Health Care Team, the counseling staff, the clinic team at the nearest POGO center, or with other personnel in the case of an emergency. Furthermore, information may be transferred and stored electronically. However, the release or transmission of any sensitive information (medical or otherwise) will be at the discretion of the Director of Nursing or his or her delegate. Furthermore, some of the biographical and/or medical information you provide may be used in program evaluation and/or research but not without the approval of the Executive Director. By signing this consent you are agreeing to the transmission and/or use of the medical/social information you have provided for the purposes described above.

I/we give my/our permission to the medical personnel of Camp Trillium or to the medical personnel selected by Camp Trillium to act on my/our behalf and administer the necessary medical care to my/our child, including transportation by employees, officers or agents of Camp Trillium for medical care. It is understood that all attempts possible will be made to contact me/us in the event that emergency care or otherwise is required.

Trillium Childhood Cancer Support Centre requests personal information about campers and families, such as name, address, phone number, email, history of illness and treatment. This information is gathered to provide service that Camp Trillium offers, to communicate with you via the newsletter and other mailings, to obtain medical and emergency care if required, to support promotional information (i.e. fundraising) and to facilitate ongoing communication. We respect and protect the privacy of our campers. We will not share your information with third parties; or divulge information to other organizations or individuals for the purpose of self or product promotion under any circumstances other than described here. Trillium will endeavor to honour any request you make to access or review the personal information collected.

We consider your provision of personal information to Camp Trillium to be your consent to your collection, use and where required disclosure of personal information as described above. In certain circumstances you may withdraw your personal information. For further information please contact our Privacy Administrator.

This health record is correct and complete as far as I/we know. This form shall remain in full force and effect until it is withdrawn or amended by giving notice to: Camp Trillium 940 Queensdale Ave. East, Hamilton, Ontario L8V 1N4

I/we agree that no notice apart from that, which is specified above, shall be considered to amend this form.

This form shall bind me/us, my/our representatives, successors and/or administrators.

Signature of Parent or Guardian: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Camper Role**

- Patient **ON** treatment for cancer
- Patient **OFF** treatment for cancer since \_\_\_\_\_ (mm/dd/yy)
- Sibling** of a child **ON** treatment for cancer
- Sibling** of a child **OFF** treatment for cancer
- Bereaved Sibling** since \_\_\_\_\_ (mm/dd/yy)

**Oncology Information** (for all patients both on and off treatment)

Type of cancer:       ALL     AML     Brain Tumour     Bone Tumour     Lymphoma     Other

Diagnosis (i.e. specific type of tumour) \_\_\_\_\_

Date of diagnosis (mm/dd/yy) \_\_\_\_\_ Date of relapse(s) if any (mm/dd/yy) \_\_\_\_\_  NA

Date treatment was completed (mm/dd/yy) \_\_\_\_\_

Date of bone marrow transplant (mm/dd/yy) \_\_\_\_\_

Graft VS. Host Disease       Yes       No

If answered Yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_

**Primary Treatment Centre** (if on treatment, the camp nurses will contact your clinic nurse 1-2 weeks prior to your camp session and ask for an update as to your current treatment: most recent blood counts, medications and any treatments to be arranged\*)

- CHEO** (Ottawa)
- KRCC/KGH** (Kingston)
- HSC/SICK KIDS** (Toronto)
- HHS/MAC KIDS** (Hamilton)
- LHSC** (London)

**Oncologist** \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_

**Clinic Nurse** \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_

Please indicate any of the following that currently apply:

- Receiving Radiation therapy                       Yes       No
- Receiving Chemotherapy                             Yes       No
- Have a Hickman/Broviac                             Yes       No
- Have a Portacath                                       Yes       No
- Have a PICC line                                        Yes       No
- Have a subcutaneous catheter (insuflon)        Yes       No
- Under palliative care team                          Yes       No

Camper will require treatment at camp\*       Yes       No       Unsure

***\*If your child requires IV or IM chemotherapy or a blood transfusion while at camp, arrangements will be made with your home clinic to have the treatment administered at the Kingston Regional Cancer Centre in Kingston on Tuesdays (for OuR Garratt's Island campers) or McMaster Children's Hospital in Hamilton on Wednesdays (for Rainbow Lake campers). Camp Trillium will provide transportation and a staff member to accompany your child .Oral chemotherapy and some venous bloodwork can be done at camp site.***

**Campers currently receiving treatment or who have been off treatment for less than one year, please have oncologist complete the following information:**

Will need Zoster Immunoglobulin for chickenpox exposure       Yes     No

Will need Immunoglobulin for measles exposure                       Yes     No

Oncologist's signature: \_\_\_\_\_      **Date:** \_\_\_\_\_

Printed name: \_\_\_\_\_

**Health Care Information**

Health card number \_\_\_\_\_ Version code \_\_\_\_\_ Province \_\_\_\_\_

Camper Weight: \_\_\_\_\_ lbs / kg Height \_\_\_\_\_ inches / cm

Family Doctor \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

Other Health Professionals / Specialists involved with camper (other than Pediatric Oncologist)

Name \_\_\_\_\_ Speciality \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Speciality \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

**General Health Questions** does the camper have/or have had

	Yes	No		Yes	No
Recent Illness or Injury	<input type="checkbox"/>	<input type="checkbox"/>	G-tube or similar device	<input type="checkbox"/>	<input type="checkbox"/>
Chronic or Recurring Illness or Condition	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/mental health diagnosis	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	ADHD	<input type="checkbox"/>	<input type="checkbox"/>
VP shunt or similar device	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	Mobility concerns/splints/prosthetic	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Uses a wheelchair	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic Appliance	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clotting Problems	<input type="checkbox"/>	<input type="checkbox"/>	Female: has had first menstruation?	<input type="checkbox"/>	<input type="checkbox"/>
Stomach/ Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>	If no to above, has she been prepared for it?	<input type="checkbox"/>	<input type="checkbox"/>

Please provide details here for questions answered **yes**: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Illness** have had:

	Yes	No	Unknown	Date (mm/yy)	
Chicken Pox.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____	<input type="checkbox"/> Pre <input type="checkbox"/> Post cancer treatment <input type="checkbox"/> NA
Shingles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____	<input type="checkbox"/> Pre <input type="checkbox"/> Post cancer treatment <input type="checkbox"/> NA
Measles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____	<input type="checkbox"/> Pre <input type="checkbox"/> Post cancer treatment <input type="checkbox"/> NA
Mumps.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____	<input type="checkbox"/> Pre <input type="checkbox"/> Post cancer treatment <input type="checkbox"/> NA
Rubella (German Measles)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____	<input type="checkbox"/> Pre <input type="checkbox"/> Post cancer treatment <input type="checkbox"/> NA

**Immunization** have had: **Yes No**

	Yes	No	Date (mm/yy)	
MMR.....	<input type="checkbox"/>	<input type="checkbox"/>	____/____	<input type="checkbox"/> Pre <input type="checkbox"/> Post cancer treatment <input type="checkbox"/> NA
DPT.....	<input type="checkbox"/>	<input type="checkbox"/>	____/____	<input type="checkbox"/> Pre <input type="checkbox"/> Post cancer treatment <input type="checkbox"/> NA
Tetanus.....	<input type="checkbox"/>	<input type="checkbox"/>	____/____	<input type="checkbox"/> Pre <input type="checkbox"/> Post cancer treatment <input type="checkbox"/> NA
Chicken Pox (Varivax).....	<input type="checkbox"/>	<input type="checkbox"/>	____/____	<input type="checkbox"/> Pre <input type="checkbox"/> Post cancer treatment <input type="checkbox"/> NA
Hepatitis B.....	<input type="checkbox"/>	<input type="checkbox"/>	____/____	<input type="checkbox"/> Pre <input type="checkbox"/> Post cancer treatment <input type="checkbox"/> NA
Other Vaccines _____			____/____	<input type="checkbox"/> Pre <input type="checkbox"/> Post cancer treatment <input type="checkbox"/> NA
_____			____/____	<input type="checkbox"/> Pre <input type="checkbox"/> Post cancer treatment <input type="checkbox"/> NA

**Medication** will camper require any medication while at camp? Yes  No  Unknown/unsure

*Please send all medications usually taken, bring enough for the duration of camp, and keep them in the originally labeled container.*

Medication	Dose	Times taken each day	Reason for taking	Special instructions

\*PLEASE SEND A CURRENT LIST WITH CAMPER, IF MEDICATIONS HAVE CHANGED SINCE FILLING OUT THIS FORM

**Allergies**

	Yes	No	Unknown	Anaphylactic*	Please give details, past reactions and usual treatment
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bee Stings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Peanuts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER (food, latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

*\*all anaphylactic campers need to bring a prescription labeled, not expired epi-pen, or twinject device to camp.*

**Nutritional Information** please check all that apply

- does not eat red meat  
 does not eat pork  
 does not eat eggs  
 does not eat dairy products  
 other \_\_\_\_\_

**For the Camp Directors** Parents, please tell us about your child! We use this information when matching special friends and making cabin and group arrangements for camp. You may attach any information not asked, that will help us ensure your child has a successful experience at camp.

Is this your child's first time to Camp Trillium?  Yes  No 1<sup>st</sup> Year \_\_\_\_\_

Has your child ever stayed overnight without a parent?  Yes  No

Does your child have any particular fears (i.e. the dark, water, animals)? \_\_\_\_\_

Has your child ever been told not to participate in any activities by a health professional?  Yes  No

Has your child experienced challenges in group settings? (at school, club, camp)  Yes  No

Is there anything else we should know about your child to make his/her stay more enjoyable?  Yes  No

**For My Special Friend** (Campers...tell us about you!)

My name is \_\_\_\_\_.

I have been to Camp Trillium for \_\_\_\_\_ years.

- I have been to:
- |  |                                    |                                      |
|--|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Residential Camp          | <input type="checkbox"/> Day Camp  | <input type="checkbox"/> Family Camp |
| <input type="checkbox"/> Winter Camp               | <input type="checkbox"/> Teen Camp | <input type="checkbox"/> Youth Group |
| <input type="checkbox"/> Trillium in the Community |                                    |                                      |

**For emergencies and for medication administration purposes, please provide a recent picture of your child.**

My favourite things about Camp Trillium are \_\_\_\_\_

Last summer I was in Group \_\_\_\_\_ at  Rainbow Lake  OuR (Garratt's) Island  Day Camp

My Special Friend was \_\_\_\_\_

My best friends at camp are \_\_\_\_\_

By the way, you may want to know these things about me (hobbies, pets, grade at school, music)