2023 SRNA Annual QOL Family Camp Application

Section One: Child's Camper Family Profile

Name:_____
(Last) (First) (Middle) (Nickname, if applicable)

Child's Rare Neuroimmune Diagnosis (choose one, if other, please fill-in): ☐ADEM ☐AFM ☐MOGAD ☐NMOSD ☐ON ☐TM ☐Other: _____

Home Address:_____
(Street)

_____
(City) (County) (State) (Zip)

Home Phone #: _____ Cell (or alternative) Phone #:_____

Date of Birth (M/D/Y): _____ Age:_____

Height (ft/in): ____ Weight (lbs): ____ Gender: ____

Race/Ethnicity
(optional):_____

Child's Primary Language:_____Parent/Guardian Primary Language:_____

Emergency Contacts: (One individual should be a parent/guardian planning to attend camp, and the second should be a contact not planning to be at camp with your family)
Emergency Contact #1 Name: _____ Phone #: _____
Email:_____ Relationship to Child:_____

Emergency Contact #2: Name: _____ Phone #: _____
Email:_____ Relationship to Child:_____

Have you previously attended an SRNA Family Camp?: ☐Yes ☐No Are you a current member of SRNA?: ☐Yes ☐No

At least one member of the household must be a SRNA Member to apply and attend camp. If you are not yet a member, please complete the membership form here: https://wearesrna.org/join/

	Parent or Legal Guardian 1	***Parent or Legal Guardian 2***
Name		
Street Address		
City, State, Zip Code		
Home Phone #		
Cell Phone #		
Primary Email Address: (please provide different email addresses)		

Who is the child living with? ☐**Both Parents** ☐ **Mother** ☐ **Father** ☐**Guardian**

Marital Status of Parents (CHOOSE ONE): ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Single**

Morgan's Wonderland Camp (MWC) and SRNA require that any camp participant aged 18 and over complete a background check screening, including a search of the National Sex Offender Registry. Upon submission of the application, you will receive a separate email to complete the screening. The link will be valid for (5) days after receipt and must be completed, received, and reviewed prior to confirming your camp attendance. Please review SRNA's Background Check Policy.

There are shared cabins and single-family cabins available on camp. Families will be housed according to size, family demographics, and specific needs by SRNA. There is not enough space on camp for each individual family to have their own cabin. If you have identified a family with whom you're both willing to share space, please indicate their name below.

Cabin Mate Request: _____

Family Member Medical Form

Please list every family member attending camp with your child. Your child with the rare neuroimmune diagnosis will be addressed separately.
If any camper/sibling is 18 years or older, please include their email address for completion of the background check requirement.

Name	Race (Optional)	Relationship to Camper	Date of Birth	Gender	Medications	Allergies (Food/Medication)
Parent 1/Guardian 1:						☐ None
Parent 2/Guardian 2:						☐ None
Sibling 1:						☐ None
Sibling 2:						☐ None
Sibling 3:						☐ None
Sibling 4:						☐ None
Sibling 5:						☐ None
Sibling 6:						☐ None

Please provide a copy of the medical insurance card (front and back) for each individual listed.

Please Note: Any Schedule II (narcotic) medications must be stored in the designated locked room in the medical center at all times. They may not be stored in your luggage, on your person, or in a shared space/cabin.

Does your child or any member of your family have a service dog that you plan to bring to camp? ☐ Yes ☐ No

If Yes, proof of the service dog's up-to-date Rabies vaccination must be submitted with the application and be applicable through the full camp dates.

MEDICATIONS

ALL prescription medications with the exception of Schedule II medications are the responsibility of the parent/guardian of the child during the camp week. All Schedule II medications must be turned into the medical staff upon arrival at camp. Do not share medications, including non-prescription medications (such as allergy pills, cold tablets, vitamins, etc., with anyone outside of your own family/children in your custody while on camp. **PLEASE BRING ENOUGH MEDICATION FOR THE FULL CAMP STAY PLUS 2 ADDITIONAL DAYS. ALL PRESCRIPTION MEDICATIONS MUST BE BROUGHT TO CAMP IN THE ORIGINAL CONTAINER(S) WITH ORIGINAL PHARMACY LABEL(S) OR ASK YOUR PHARMASCIST FOR AN EXTRA, FULLY LABELED CONTAINER FOR USE AT CAMP.**

I hereby give permission for the camp medical staff to administer my child/family member the following (or similar brand of) over-the-counter medication deemed necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise. Check all that apply:

- ☐ Headache----------Acetaminophen or Ibuprofen
- ☐ Upset Stomach----------Pepto Bismol
- ☐ Poison Ivy----------Hydrocortisone cream
- ☐ Allergy/Congestion/Cold------Benadryl/Sudafed
- ☐ Diarrhea----------Imodium AD
- ☐ Menstrual Cramps---------Ibuprofen
- ☐ Constipation----------Dulcolax/Fleet Enema/MiraLax

_____ _____

Signature of Parent/Legal Guardian Date Signature of Parent /Legal Guardian Date

Family Immunization Form

Please list every family member attending camp.

All participants are required to have up-to-date childhood vaccinations and as required for school attendance. **Please complete the following information and provide a copy of each child's immunication record.**

If exempt, please provide exemption documentation as provided to your child's school and signed by a licensed health care provider or public health department, or clergy member, for each participant.

Name	Diptheria/Tetanus/ Pertussis (or DPT, or Tdap)	Measles/Mumps/ Rubella (or MMR)	Polio	Haemophilus influenzae type b (or Hib)	Medical or Religious Exemption
	(please indicate date of last booster/vaccination, if applicable)				
Parent/Guardian 1:					☐ I am exempt for medical or religious reasons and will provide an appropriate exemption form.
Parent/Guardian 2:					☐ I am exempt for medical or religious reasons and will provide an appropriate exemption form.
Child Diagnosed:					☐ My child is exempt for medical or religious reasons and will provide an appropriate exemption form.
Sibling 1:					☐ My child is exempt for medical or religious reasons and will provide an appropriate exemption form.
Sibling 2:					☐ My child is exempt for medical or religious reasons and will provide an appropriate exemption form.
Sibling 3:					☐ My child is exempt for medical or religious reasons and will provide an appropriate exemption form.
Sibling 4:					☐ My child is exempt for medical or religious reasons and will provide an appropriate exemption form.
Sibling 5:					☐ My child is exempt for medical or religious reasons and will provide an appropriate exemption form.
Sibling 6:					☐ My child is exempt for medical or religious reasons and will provide an appropriate exemption form.

**Please submit a copy of each child's current immunization record along with the application.

**If parents/guardians have an available record, please submit as well. If you do not have documented records for verification, parent/guardian may attest and sign below.

**If a medical or religious exemption is noted, an appropriate exemption form (as approved by your specific state, school, or local health department) must be submitted.

☐ Parent/Guardian #1: I attest that I am up-to-date for the aforementioned communicable diseases however, do not have access to vaccine records/documentation for verification. Signature: _____

☐ Parent/Guardian #2: I attest that I am up-to-date for the aforementioned communicable diseases however, do not have access to vaccine records/documentation for verification. Signature: _____

Section Two: Child Diagnosed Medical Form & Physician Statement

The health and well-being of campers and volunteers are supervised by our volunteer medical staff. Please complete **all** requested information in the following sections. Please include any additional health concerns you may have that are not specifically requested in the spaces provided. To the extent any information is designated as protected health information under the Health Insurance Portability and Accountability Act (HIPAA), SRNA agrees to abide by all applicable laws. The health history and medications are to be reviewed by the child's treating physician or healthcare professional (e.g., PA or NP) and the accompanying Physician Statement be completed and signed.

Name of your child's family physician/pediatrician: _____ Phone #: _____
Name of your child's neurologist/specialist: _____ Phone #:_____

MEDICAL INSURANCE COVERAGE
Insurance Carrier:_____ Policy Holder's Name:_____
Policy #:_____ Group #:_____

Please submit a copy of the front and back of the insurance card along with this form.

Health History

Does your child have any known MEDICATION ALLERGIES? (CHOOSE ONE) ☐YES ☐NO If yes, please explain: _____

Does your child have any known FOOD ALLERGIES? (CHOOSE ONE) ☐YES ☐NO If yes, please explain: _____

Does your child have any known additional ALLERGIES (e.g. sun, latex, plants, etc.)? (CHOOSE ONE) ☐YES ☐NO
If yes, please explain: _____

Does your child use any adaptive devices? ☐Manual wheelchair ☐Power chair ☐Walker ☐Crutches ☐Orthotics/Braces ☐Other
If "Other" is chosen, please explain:_____

In the box below: Mark NOW if your child currently has, PAST if they did have, or leave blank if never had.

☐Now ☐Past	ADD/ADHD	☐Now ☐Past	Cognitive Delay	☐Now ☐Past	Frequent Colds	☐Now ☐Past	Kidney Disease	☐Now ☐Past	Swimmer's Ear
☐Now ☐Past	Anxiety/Depression	☐Now ☐Past	Constipation	☐Now ☐Past	Hayfever	☐Now ☐Past	Panic Attacks	☐Now ☐Past	Urinary Tract Infection
☐Now ☐Past	Asthma	☐Now ☐Past	Diabetes	☐Now ☐Past	Headaches	☐Now ☐Past	Peanut/Nut Allergy*	☐Now ☐Past	Wheezing
☐Now ☐Past	Back/Neck Pain	☐Now ☐Past	Diarrhea	☐Now ☐Past	Heart Conditions	☐Now ☐Past	Pet Allergy*	☐Now ☐Past	Seizures
☐Now ☐Past	Bee Sting Reactions*	☐Now ☐Past	Ear Infection	☐Now ☐Past	Hepatitis/Hepatitis Exposure	☐Now ☐Past	Pneumonia	☐Now ☐Past	
☐Now ☐Past	Bladder Control Problems	☐Now ☐Past	Eating Disorder	☐Now ☐Past	Homesickness	☐Now ☐Past	Scoliosis	☐Now ☐Past	
☐Now ☐Past	Bleeding/Clotting Disorders	☐Now ☐Past	Emotional Problems/Self Injurious Behavior	☐Now ☐Past	Hypertension/High Blood Pressure	☐Now ☐Past	Severe Menstrual Cramps	☐Now ☐Past	
☐Now ☐Past	Cerebral Palsy	☐Now ☐Past	Fainting Spells	☐Now ☐Past	Indigestion	☐Now ☐Past	Sinusitis	☐Now ☐Past	

* If you indicated any allergies above, do your allergies require an Epipen to relieve symptoms? (CHOOSE ONE) ☐YES** ☐NO
**If yes, you are required to bring an Epipen with you to camp.
If you answered "NOW" to any of the above questions, please explain in detail: _____

Is there any other physical, medical or emotional information that the medical staff should be aware of (e.g. special diet, pregnancy, motion sickness, recent surgeries, serious injuries, depression, suicide threats or attempts, eating disorder, anxiety disorder, etc.)?

_____

_____

Are upcoming surgeries or new medical equipment on order that you child will receive prior to camp? If yes, list nature of surgery, proposed date and/or new medical equipment (if applicable). _____

Are there any activity restrictions for your child while participating at camp? If yes, please explain._____

_____

Has your child been exposed to a communicable disease (e.g. head lice, strep throat, mononucleosis, etc.) in the last six (6) months?
(CHOOSE ONE) ☐YES ☐NO If yes, please describe:_____

_____

IMPORTANT: YOU ARE REQUIRED TO NOTIFY THE EFTX OFFICE IF YOUR CHILD HAS BEEN EXPOSED TO A COMMUNICABLE DISEASE AFTER SUBMISSION OF THIS APPLICATION.

Does your child require any respiratory equipment (e.g. Bi-Pap, C-Pap, Cough Assist, Inhaler, etc.)?(CHOOSE ONE) ☐YES ☐NO
If yes, please detail each piece of equipment and when it should be used: _____

_____

Does your child wear glasses, contacts, hearing aid, retainer, helmet, etc.? (CHOOSE ONE) ☐YES ☐NO
If yes, please describe each piece of equipment and when it should be used: _____

_____

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☐Upset Stomach----------Pepto Bismol
☐Poison Ivy----------Hydrocortisone cream
☐Allergy/Congestion/Cold------Benadryl/Sudafed
☐Diarrhea----------Imodium AD
☐Menstrual Cramps---------Ibuprofen
☐Constipation----------Dulcolax/Fleet Enema/MiraLax

_____ _____

Signature of Parent/Legal Guardian Date Signature of Parent /Legal Guardian Date

Please complete the listing below with all medications, including non-prescription or over-the-counter medications such as dietary supplements your child is taking and the schedule by which they are given. (Attach a separate sheet detailing all other medications if additional writing space is required.

Medication	Strength of each pill (MG)	Times and how medication is given? (e.g. at meals, crushed in food, etc.)	Purpose of medication?

SRNA Annual QOL Family Camp 2023: Physician Statement

This section is to be completed by your child's neurologist or primary medical professional (e.g., pediatrician, PA, NP, physiatrist, etc.) who is familiar with your child's diagnosis. This professional should be best able to determine if your child is eligible to attend SRNA Family Camp. This evaluation must take place no more than twelve months prior to the start of the camp session.

Camper's Name:_____ Age: _____

Vital Signs: Height:_____ Weight: _____ Pulse:_____

Resp. Rate (resting):_____ Blood Pressure (Resting, Sitting): _____

General Inspection:_____

	Status, Essential Findings, Deviating from Normal
Head	
Eyes/Vision	
Nose	
Mouth/Teeth	
Ears/Hearing	
Neck/Thyroid	
Thorax/Lungs	
Heart	
Abdomen/Hernia	
Skin	
Lymphatics	
Spine	
Extremities	
Emotional Status	

Recommendations and/or Restrictions while at camp:

Swimming: _____

Adaptive Sports: _____

Diet:_____

Strenuous Activity:_____

Other:_____

Note to Health Provider:

1. Participation involves group living and activities in an outdoor setting, a high level of physical activity, adaptive sports and swimming**. In your medical opinion, is the SRNA QOL Family Camp an appropriate environment for this child?**
   (CHOOSE ONE) ☐**YES** ☐**NO**
2. **Is it your opinion that this child is medically and emotionally able to engage in camp activities (e.g. daily physical activity and adaptive sports), except as noted above?**
   (CHOOSE ONE) ☐**YES** ☐**NO**

_____ Print Physician/Medical Professional's Name

_____ Physician/Medical Professional's Signature

_____ Date

_____ Address

_____ City

_____ Phone Number

Section Three: SRNA Family Camp Policies

Please read the following carefully and then sign the statement of compliance that follows. Parents should discuss the following policies with their children.

ALCOHOL, DRUGS, AND WEAPONS ARE FORBIDDEN: The possession or use of alcoholic beverages or illegal drugs or drug paraphernalia are strictly forbidden and will be grounds for immediate dismissal from camp. The possession of any weapon (firearm, knife (pocketknife), explosives, etc.) is strictly forbidden on camp property. The weapon will be confiscated, and the participant will be dismissed from camp.

RESPECT: Each camp participant—including campers, volunteers, assistant directors, activity staff, medical staff, and administrative staff—has a RESPONSIBILITY to respect the camp leadership, as well as the health and well-being of the camp community. Each camp participant is expected to be a considerate cabin mate and be respectful to people and their belongings. Profanity is not allowed and hazing, and initiations are not permitted.

MEDICAL SERVICES: SRNA Family Camp will provide medical care by the designated Camp Physician to anyone who becomes ill or injured during the camp session. All treatment and/or health care will be administered by authorized and licensed medical team members. Medication (prescription and over-the-counter) must be kept in the medical center and dispensed by medical staff. The medical staff must be advised promptly of any injuries, allergies, or health problems. Local emergency authorities will be called for assistance as necessary for treatment and/or transportation to the nearest treatment facility.

MORAL BEHAVIOR: Everyone at camp is expected to behave in a morally upstanding way. Obscene, pornographic, or lewd materials are not allowed. Any obscene or sexual activity at camp is strictly forbidden.

CURFEW: Everyone is urged to get enough sleep to be able to function effectively throughout the day. All campers and volunteers are expected to return to and remain in their sleeping quarters with lights out by curfew. These curfews will be strictly enforced, and breaking curfew may result in the camp participant's immediate dismissal from camp.

CAMPGROUNDS: SRNA leases the facility to host the camp session. The camp's facilities and equipment should be treated with the utmost care and respect. All camp participants should take care not to damage or destroy any camp property and to be considerate of all wildlife on the campgrounds.

ACTIVITY SCHEDULE: Camp participants are expected to take part in the daily camp program by following the camp schedule and attending activities. Schedule is subject to change.

SMOKING: Smoking, vaping or tobacco use is not permitted on campgrounds or in any camp facility.

SUPERVISION: All campers under the age of 18 *must be always accompanied and supervised by a parent/guardian* except during designated parent/guardian educational sessions when SRNA volunteers will be assigned to supervision of the minor children in attendance. It is critical for the safety of all campers that parents/guardians adhere to and always maintain supervision of their children.

VISITORS: No visiting is permitted including family and friends of camp participants during the week of camp.

VALUABLES: There is no need to bring valuable clothing, accessories, computer, or camera equipment. SRNA and MWC are not responsible for loss or damage to personal property.

I (my family) have read the SRNA Family Camp Policies and agree to abide by the policies detailed in this agreement as well as those established by the Camp Coordinator and his/her designated camp assistants. I am (we are) fully aware that adhering to the above and any camp facility rules will be my (my family's) sole responsibility. Deviation from these policies and rules may be cause for immediate dismissal from the camp and I (we) will have to make arrangement for transportation at my (our) sole expense. I (we) understand that parents/guardians (we) will be notified of the above action of our children.

I have read and reviewed the policies with my child and agree to abide by the SRNA Family Camp Policies detailed in this application as well as those established by the Camp Director, Camp Coordinator, and his/her designated camp assistants.

_____
Parent/Guardian #1 Signature

_____
Parent/Guardian #2 Signature

_____
Date

Section Four: Attestation/Releases/Waivers

The health history you have provided in the SRNA QOL Family Camp Application will be relied upon if you or your child has an accident or an injury so it is extremely important that you fill out this information to the best of your knowledge. I authorize the SRNA QOL Family Camp directors, counselors medical staff, and volunteers to obtain medical treatment for myself or my child and to transport them for this purpose if necessary. I give permission to the Camp Physician selected by SRNA to order X-rays, routine tests, and treatments; and, in the event of any perceived emergency, I give permission to the medical staff selected by SRNA to obtain appropriate/proper treatment for myself or my child(ren). I understand that payment of any medical expenses incurred by myself, or my child(ren) will be my sole responsibility.

_____
Parent/Guardian #1 Signature and Date

_____
Parent/Guardian #2 Signature and Date

I (we) acknowledge and agree that I (we) have fully and truthfully completed the application in its entirety and attest to the accuracy and validity of the information provided in this application, including all forms requested, any waivers, releases, and/or questionnaires that may be required of me by SRNA and/or MWC as a condition to participate in the SRNA QOL Family Camp event.

_____
Parent/Guardian #1 Signature and Date

_____
Parent/Guardian #2 Signature and Date

I hereby grant permission to The Siegel Rare Neuroimmune Association (SRNA) to utilize my (or my children's) name, biographical material, appearance, performance, or voice in any and all manner and media throughout the world for the purpose of promoting, reporting or publicizing SRNA. By signing this form, I also permit SRNA to use any material or parts of materials submitted to SRNA such as stories, articles, essays, blogs for the purpose of promoting, reporting or publicizing SRNA. I understand that no royalty, fees, or any other compensation shall become payable to me by reason of such release.

_____
Parent/Guardian #1 Signature and Date

_____
Parent/Guardian #2 Signature and Date

If accepted to participate in The SRNA Annual Quality of Life Family Camp to be held from July 2-6, 2023 at Morgan's Wonderland Camp (MWC), in San Antonio, Texas, I understand that any Medical or Professional Volunteers attending the SRNA Family Camp have been invited by SRNA to join us solely as camp volunteers and to participate in an educational program during the camp, and not for the purpose of providing medical advice to me and my family. I accept that any medical advice provided by the Medical or Professional Volunteers should only be considered a recommendation and that I should consult with my doctor about the information provided.

Please check each box and sign below:

☐ I hereby waive, release, and discharge SRNA from any and all liability for the medical advice provided by the Medical Volunteers at Camp.

☐ I hereby waive, release, and discharge Medical Volunteers from any and all liability for the medical advice provided by them at Camp.

☐ I have carefully read this agreement and fully understand its contents.

_____
Parent/Guardian #1 Signature and Date

_____
Parent/Guardian #2 Signature and Date

PLEASE SUBMIT THE APPLICATION AND ALL REQUESTED DOCUMENTS TO SRNA VIA THIS LINK:
https://www.dropbox.com/request/5PSpkTrjxdGW81IIt6Qm
SECTION TWO, CHILD DIAGNOSED MEDICAL FORM & PHYSICIAN STATEMENT MAY BE SUBMITTED SEPARATELY, AFTER COMPLETION HOWEVER, CAMP ATTENDANCE IS CONTINGENT ON RECEIPT OF SECTION TWO