



## Kay's Kamp LIT Application

Thank you so much for your interest in Kay's Kamp. Kamp will run from Saturday, August 7, 2010 through Saturday, August 14, 2010. All LIT applicants can attend free of charge. Attached you will find an application that needs to be completed by the LIT applicant. Please make sure that you sign all appropriate areas. **Application deadline is June 1, 2010.** If you have received this application after this date or are having difficulty in completing before this deadline, please contact me ASAP at [lisa@kayskamp.org](mailto:lisa@kayskamp.org)

In order to be considered for the LIT program, you must complete the following:

- Personally complete this entire application
- A personal interview with the LIT Director or Kamp Director
- A successful criminal background check
- Attend staff orientation on August 7<sup>th</sup> (details to follow)

The last two pages are a required authorization that is needed from your physician or nurse practitioner. **We do not need these forms to process your application, but we do need these forms in order for you to attend Kamp.** Please do not let this form hold up sending in your application, you can always send or fax it to us later. Once you have all required information and signatures, please forward the application to the following address:

Kaylyn Elaine Warren Foundation  
560 Peoples Plaza #111  
Newark, DE 19702  
Attn: Camper Application  
Or fax it to:  
(302)-836-8534

**Please be sure to include the following with your application:**

- Copy of your Driver's License or photo identification**
- Copy of Medical Insurance Card, front & back**
- Copy of most recent blood work if you are currently on therapy**

Once we have received your completed application, it will be reviewed and your references will be checked. Once your references have been checked, we will contact you to set up an interview. Please make sure to regularly check the Kamp website at [www.kayskamp.org](http://www.kayskamp.org) for updates on information.

Please do not hesitate to contact me at [lisa@kayskamp.org](mailto:lisa@kayskamp.org). I look forward to meeting you! Go Kamp!!

Lisa Schmalbach  
Executive Director  
Kamp Director

**\*\*FOR USE BY KAMP STAFF ONLY\*\***  
**Enter the date for the following information**

Application received: \_\_\_\_\_ Complete Original application given to Volunteer Coordinator \_\_\_\_\_  
Complete copy given to Kamp Director \_\_\_\_\_ Medical Director \_\_\_\_\_



## Kay's Kamp LIT Application

General Information			
Name		Preferred name for nametag	
Street Address			
City		State	Zip
Home Phone			
D.O.B.	Current grade in school		Age at camp
Male <input type="checkbox"/>	Female <input type="checkbox"/>	email address	
Do you have a Caring Bridge, Care Page or other Web Page that may become accessible to Kamp staff?			
T-Shirt size    YS <input type="checkbox"/> YM <input type="checkbox"/> YL <input type="checkbox"/> AS <input type="checkbox"/> AM <input type="checkbox"/> AL <input type="checkbox"/> AXL <input type="checkbox"/> AXXL <input type="checkbox"/>			
Do you have siblings? yes <input type="checkbox"/> no <input type="checkbox"/>		Name/age of sibling(s)	
Diagnosis		Date of Diagnosis	
Currently: on therapy <input type="checkbox"/> off therapy <input type="checkbox"/>			
Name of Parents/Guardian			
Relationship to child		Parent/guardian email	
Home Phone		Work Phone	Cell Phone
May Kay's Kamp contact you and send correspondence through email? Yes <input type="checkbox"/> No <input type="checkbox"/>			
May we publish your address, phone number and email in the <i>Counselor</i> directory? yes <input type="checkbox"/> no <input type="checkbox"/>			
May we publish your address, phone number and email in the <i>Camper</i> directory? yes <input type="checkbox"/> no <input type="checkbox"/>			
<b>Emergency Contact</b> – <i>Please list two alternative adults to contact in case of an emergency if parent/guardian cannot be reached. Must be someone OTHER than parent/Guardian.</i>			
1. Name		Relationship	
Home Phone		Work Phone	Cell Phone
2. Name		Relationship	
Home Phone		Work Phone	Cell Phone

Briefly explain your reason(s) for volunteering to be a LIT at Kay's Kamp.



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Please describe any past leadership experience or skills that you have to offer to Kay's Kamp.

What do you expect to gain from participating in the LIT program at Kay's Kamp?



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Please answer the following essay question in the space provided below (you may attach additional sheets if needed):

How do you think being a LIT is different from being a camper? How do you think you would handle these differences? What would you do to be sure that you were not acting like a camper? Tell us who is the best youth leader you've ever met? This could be your teacher, youth group leader, camp counselor – anybody. Why do you believe they were so good? What did they do or say that makes you believe that they were good?



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Please list three (3) people who are not your relatives to serve as references. Please include one (1) former employer (if you have previous work experience) and two (2) people that can attest to your character and ability to work in different situations.

Reference #1		
Name of Reference	Relationship	
Phone	Email address	
Street Address		
City	State	Zip
Reference #2		
Name of Reference	Relationship	
Phone	Email address	
Street Address		
City	State	Zip
Reference #3		
Name of Reference	Relationship	
Phone	Email address	
Street Address		
City	State	Zip

Have you ever been convicted of a felony or misdemeanor other than minor traffic offenses?  
**yes**  **no**  If yes, please attach an explanation.

**Note:** A prior conviction or accusation is not an automatic bar from volunteering. The type of conviction or accusation will be evaluated by Kay's Kamp before any decision is made.

Kay's Kamp policy is to prohibit all forms of harassment by our volunteers. This includes sexual, racial, religious, and other forms of harassment. Have you ever been accused of harassment of any person including, but not limited to, workplace harassment? **Yes**  **no**  If yes, please attach an explanation.



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**AUTHORIZATION TO PERFORM CRIMINAL BACKGROUND CHECK**

I, \_\_\_\_\_, hereby authorize Kay's Kamp to obtain information pertaining to any charges I may have for federal and state criminal law violations. This information will include convictions committed upon minors and adults and will be gathered from any law enforcement agency of this state or any other state or federal government to the full extent permitted by law.

I understand that such access is for the purpose of considering my application as a volunteer and that I expressly DO NOT authorize the Kamp, its' directors, officers, employees or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of applicant)

**PHOTOGRAPHIC AND VIDEO CONSENT**

I, \_\_\_\_\_, consent that photographic and/or video pictures may be taken for the purpose of obtaining publicity for Kay's Kamp or for providing documented materials to be shared with campers and staff. Such use may include, but shall not be limited to any advertisements, documentation of camp activities, or promotion on television, radio, newspaper, magazine, promotional film, webpage, flier, etc.

I understand there will be no compensation for the use of such materials and that materials, so used, shall remain the property of the Kaylyn Elaine Warren Foundation. I agree to hold harmless the Kaylyn Elaine Warren Foundation, its employees, legal representatives or assigns and all persons acting under their authority from any liability that may arise from publication of such photographic and/or video material.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of applicant)

**AUTHORIZATION FOR MEDICAL TREATMENT**

As a volunteer of Kay's Kamp, I, \_\_\_\_\_, agree that any medical/surgical emergency is my financial responsibility.

In case of a medical and/or surgical emergency I authorize the Kay's Kamp medical team to render care or arrange for any x-rays, anesthetic, medical, dental, or surgical diagnosis, surgery or treatment and hospital care which is deemed advisable to and is under the supervision of any duly licensed physician, dentist or surgeon.

I acknowledge that certain activities at Kay's Kamp may have an increased risk of injury. I assume full responsibility of my safety. I agree to release and indemnify Kay's Kamp, the Kaylyn Elaine Warren Foundation, and all of it's agents, representatives, employees (paid or voluntary) from any claims, costs, expenses, and/or damages which I may sustain or incur by joining in such activities, unless restrictions for such activities are noted by myself or my physicians.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of applicant)



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**LIT HEALTH HISTORY FORM**

This form is required by all LIT applicants. Kay's Kamp will not be able to complete this form for you. You must obtain doctor/PNP signature on page 12 and 13. Please complete the following information so that the Kamp can be aware of all of your needs.

Last Name		First		M.I.	Today's Date	
Home Address					Apt. #	
City			State		Zip	
SSN		Gender male <input type="checkbox"/> female <input type="checkbox"/>		DOB		
Diagnosis		Date of Diagnosis		<input type="checkbox"/> on <input type="checkbox"/> off therapy		
Work Phone			Cell Phone			
Name of Oncologist			Phone			
Oncologist Hospital Affiliation:						
Address						
Name of pediatrician/family doctor:			Phone			
Address						
Name of Dentist			Phone			
Address						
#1 Emergency Contact			Relationship			
Phone (H)		Phone (W)		Phone (C)		
If emergency contact is not available, notify #2 Emergency Contact:						
Phone (H)		Phone (W)		Phone (C)		
<b>Insurance Information</b>						
<b>Primary Medical Insurance Information</b>						
Insurance Company Name						
Street Address			City		State	Zip
Policy Holder's Name			Policy or group #			
Phone Number						
<b>Secondary Medical Insurance Information</b>						
Insurance Company Name						
Street Address			City		State	Zip
Policy Holder's Name			Policy or group #			
Phone Number						
<input type="checkbox"/> Please check this box if your child currently DOES NOT have insurance coverage						
<b>** PLEASE PHOTOCOPY FRONT AND BACK OF HEALTH INSURANCE CARD AND ATTACH TO THIS FORM **</b>						



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**Allergies**

Please list all known medication, food allergies, and environmental allergies.  
(Include insect stings, hay fever, asthma, etc.)

Allergy	Describe reaction and management of the reaction

**Additional Medical History**

Medical Diagnosis	Approximate Date of Diagnosis	Any Recent Complications or Changes

**Surgical History**

Surgery	Date, most recent first	Any Complications resulting from surgery

**Specialists and/or Therapists**

Specialist ( <i>Neurologist, Cardiologist, etc...</i> ) or Therapist ( <i>Occupational, Physical, etc...</i> )	Date of last Appointment	Specific Issue(s) for Which Child is Being Seen



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### Medications

The medical staff will store and administer any medications needed during the Kamp session. Please send all medications to Kamp with your child in their original container with written instructions. It is expected that each family will supply in advance any routine medications needed.

Please have your doctor write an order describing the dose and method of administration (including chemotherapy, TPN, antibiotics or other infusion). It is necessary for you to arrange the transport of these medications to Kamp with your healthcare team.

If you are on therapy, please send the most recent blood counts to Kamp with you for comparison to any counts which may be needed at Kamp.

I take no medication on a routine basis

I have a port.     I have a central line. (Date of Insertion: \_\_\_\_\_)

\* If you have a central line, please bring the necessary supplies for central line care and flushing. Send enough supplies for at least daily changes.

I take the following medications on a routine basis:

DRUG	DOSE	TIME	DAYS OF WEEK

Please explain any restrictions to activity (ex: what cannot be done, what adaptations or limitations are necessary).

Dietary restrictions (please be specific).



## Kay's Kamp LIT Application

General Questions (please check yes or no)

### Have you:

1. Had any recent injury, illness or infectious disease? Yes  No
2. Have a chronic or recurring illness/injury? Yes  No
3. Been hospitalized in the past 18 months? Yes  No
4. Had surgery in the last 18 months? Yes  No
5. Have frequent headaches or migraines? Yes  No
6. Had a head injury? Yes  No
7. Been knocked unconscious? Yes  No
8. Wear glasses, contacts or protective eyewear? Yes  No
9. Passed out during or after exercise? Yes  No
10. Been dizzy during or after exercise? Yes  No
11. Had seizures? Yes  No
12. Had chest pain during or after exercise? Yes  No
13. Had high blood pressure? Yes  No
14. Been diagnosed with a heart murmur? Yes  No
15. Had back problems? Yes  No
16. Had problems with joints (knees, ankles, etc.)? Yes  No
17. Have any skin problems (itching, hives, rash, acne)? Yes  No
18. Have diabetes? Yes  No
19. Have asthma? Yes  No
20. Had mononucleosis in the past 12 months? Yes  No
21. Had problems with diarrhea/constipation? Yes  No
22. Have problems sleepwalking? Yes  No
23. If female, have abnormal menstrual history? Yes  No
24. Had an eating disorder? Yes  No
25. Have ADD/ADHD? Yes  No
26. Have Developmental Delays? Yes  No

Please explain any "Yes" answers, noting the number of the question.

Which of the following has your child been diagnosed with in the past?

Please check all that apply and give approximate date of diagnosis.

- |                                  |   |   |
|----------------------------------|---|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox or Shingles    | <input type="checkbox"/> German Measles (Rubella) |
| <input type="checkbox"/> Mumps   | <input type="checkbox"/> Pertussis (Whooping Cough) |   |





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**THE NEXT TWO PAGES TO BE COMPLETED BY PHYSICIAN OR PNP  
Physician/PNP Recommendations and Restrictions at Kamp**

I examined \_\_\_\_\_ on \_\_\_\_\_  
Camper's full name date of most recent examination

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ BMI: \_\_\_\_\_ BP: \_\_\_\_\_ HR: \_\_\_\_\_ RR: \_\_\_\_\_

**Last blood count:** Date: \_\_\_\_\_ Hgb \_\_\_\_\_ Hct \_\_\_\_\_ WBC \_\_\_\_\_  
Platelets \_\_\_\_\_ ANC \_\_\_\_\_ Varicella Titer \_\_\_\_\_

**Current physical and medical condition:** X=within normal limits O=See remarks below

\_\_\_ scalp, skin \_\_\_ heart \_\_\_ vision \_\_\_ ear, nose \_\_\_ lungs  
\_\_\_ hearing \_\_\_ throat \_\_\_ abdomen \_\_\_ neck \_\_\_ eyes  
\_\_\_ genitalia \_\_\_ teeth \_\_\_ extremities \_\_\_ lymph nodes \_\_\_ nervous system

REMARKS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Chemotherapy.** Please include a copy of current chemotherapy roadmap or regimen.

\_\_\_\_\_  
\_\_\_\_\_

Any medically-prescribed meal plan or dietary restrictions: \_\_\_\_\_  
\_\_\_\_\_

Description of any limitation, concern or restriction on Kamp activities:  
\_\_\_\_\_  
\_\_\_\_\_

**I hereby verify that the information on the above form and preceding forms containing health matters and medications are correct. In my opinion, this individual is able to participate in Kay's Kamp Summer Kamp.**



**Signature of Physician/Practitioner** \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Phone \_\_\_\_\_



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*Dear Physician or PNP,  
Kay's Kamp, the First Oncology Camp in Delaware, is requesting a few moments of your time to complete the following data on your patient, \_\_\_\_\_ (DOB \_\_\_\_\_). This information is requested on individuals in treatment and on survivors in order to understand their current health status and ongoing health risks so the medical staff can be adequately prepared and provide the best possible care. Thank you in advance for your assistance.*

**Amanda Kay, MD**  
*Medical Director, Kay's Kamp*

I authorize the release of the requested medical information below of, \_\_\_\_\_ (DOB \_\_\_\_\_), to the Kay's Kamp Medical Team. I understand this information will be used solely by the Kamp medical staff for the purpose of ensuring the safe care and well being of me while at Kay's Kamp. Please complete and return by Fax to the Kay's Kamp Medical Team as soon as possible at: **302-836-8534**.

Print Name: \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Primary Diagnosis:** \_\_\_\_\_ **Date of Diagnosis:** \_\_\_\_\_

**Additional Diagnoses:** \_\_\_\_\_

**Date of Initiation of Treatment:** \_\_\_\_\_

**Date of Treatment Completion, if applicable:** \_\_\_\_\_

**Treatment Protocol followed:** \_\_\_\_\_

**Chemotherapy Type(s) Used:** \_\_\_\_\_

**Radiation Used:** Yes No

**If Yes, Site/Field:** \_\_\_\_\_ **Total Dose** \_\_\_\_\_

**Follow-up Imaging and Studies, as applicable to treatment and diagnosis:**

Study	Date	Findings, if any
ECHO		
EKG		
Pulmonary Function Test		
Chest X-ray		
CT/MRI		
Thyroid function studies		
Renal function studies		
Urinalysis		
Liver function studies		
DEXA or bone density study		
Hearing exam		
Ophthalmology exam		

**Additional Information:** \_\_\_\_\_