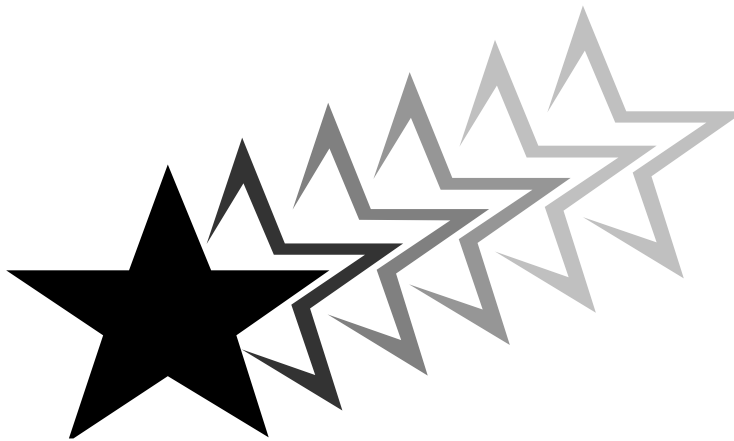




2019 Camp Shining Stars



Sunday, August 4 – Friday, August 9, 2019

Camp Shining Stars welcomes all children between the ages of 7 and 18 with kidney-related diagnoses.

For more information about **Camp Shining Stars**, please call the
UT Houston Pediatric Nephrology Office at (713) 500-5670 or
send an email to info@KidneyKamp.org.

Check us out on Facebook @ www.facebook.com/KidneyKampFoundation



2019 Camp Shining Stars

May 2019

Dear Parents/Guardians:

The Kidney Kamp Foundation would like to invite your child to participate in our annual **Camp Shining Stars**, a summer camp program for children with chronic kidney diseases. The Kidney Kamp Foundation, the National Kidney Foundation of Louisiana, your doctors, nurses, and other camp volunteers are committed to this important summer getaway. **Camp Shining Stars** will be held at the Camp For All facility in Burton, Texas, 11 miles North of Brenham. Camp dates are **Sunday, August 4– Friday, August 9, 2019**.

Camp Shining Stars offers air-conditioned, cabin-style sleeping quarters, complete with fully accessible restrooms and shower facilities in each cabin. All areas of the campground are fully accessible, including the swimming pool. Paved sidewalks throughout the camp allow for ease of mobility and enjoyment by all.

Activities at camp include, but are not limited to: **horseback riding (must wear long pants)**, **arts and crafts**, **archery**, **campfires and cookouts**, **swimming**, **talent show**, **canoeing**, **ropes challenge course**, **game show**, **team sports**, and **dances**. **As always, there will be new activities this summer!**

The camp is equipped with a 24-hour Health/Medical Center that is staffed by professional volunteers from Children's Memorial Hermann Hospital and other area professionals who attend to the medical needs of your child. Parents, campers must wear closed toe shoes at all times.

If you would like your child to enjoy the fun and excitement of summer camp, please take a moment to **thoroughly read and complete** the enclosed application. Don't forget to **sign the mandatory consent forms** for all children who plan to attend camp.

Please return the completed application on or before **Friday, June 28, 2019**. Also, please note that camp regulations require **prior approval** from your child's nephrologist or physician **before** they will be considered to attend camp.

Your costs associated with camp are as follows:

- ❑ \$30 fee per camper for bus transportation to and from camp (pick-up at a designated site only). Bus transportation is recommended, but parents may drive their children to and from camp. Directions will be provided.
- ❑ Any airfare required to get you to/from Houston
- ❑ All camper medical supplies **and equipment** for the week of camp
- ❑ All personal toiletries, including sunscreen and bug repellent for the camper

Please take the time to **accurately complete** all required forms. The checklist on Page 5 has been provided to ensure completeness. **We suggest that you complete the application and sign all consent forms and return them immediately to the Camp Shining Stars** address at the end of this letter. Then you can work with your child's doctor to get the medical forms completed. When you have completed the medical/physical approval forms from your child's nephrologist/physician, return the documents by Friday, June 28, 2019. This year, there is a separate online registration and consent form. **You will need to go to www.campforall.org to register prior to arriving at camp.**

We want **Camp Shining Stars** to be a pleasant experience for everyone; therefore **certain behavior will not be tolerated**. If your child does not abide by the rules and regulations of Camp for All and **Camp Shining Stars**, he/she may be asked to leave camp or not invited to return. If this should happen, please be available to come and pick up your child at camp. Above all, we want camp to be a fun and enriching experience for you, your child, and all participants. Please review the following with your child:

- ❑ Show respect for counselors, camp and medical staff and fellow campers at all times.
 - ❑ No fighting with other campers or staff
 - ❑ No foul language-verbal or written.
 - ❑ No alcohol, non-prescribed or illegal drugs or weapons.
 - ❑ No jokes, language or pranks considered demeaning, or disrespectful or insulting.
 - ❑ No destruction or stealing of camp property or other people's property.
1. Please make sure your child has everything he or she may need for camp. The necessary items are included on the enclosed checklist,
 2. Camp medications. We are not a hospital and **YOU** must supply all medicines for your child for the week of camp. Please include up-to-date written instructions on doses and times for all medications and send them in original pharmacy

containers. **If possible, ask your child's doctor to convert ALL medication to pill/tablet form for the week.** Pills are MUCH easier to dispense at camp than liquid dosing.

3. A head check will be performed at camp and your child may be sent home if lice are found.
4. Please label everything you send (your child's clothing, bedding, and luggage) with his/her first and last name prior to arriving at the bus or camp.
5. Camp For All has extremely strict rules about visitations and entry onto their property. To insure the safest environment for your child, all visitors must first contact the Kidney Kamp Foundation office at (713) 500-5670 before visiting camp. No one can show up at camp unannounced. It is the responsibility of our office to clear all visitors and notify Camp For All administration before anyone will be allowed to enter onto camp property.

FREQUENTLY ASKED QUESTIONS

Q: How much does camp cost?

A: Camp is free for the campers. Costs are covered by donations from Kidney Kamp Foundation. Those who will ride the bus to or from camp will pay \$30.00 per person for bus fare. Though not required, if you are financially able we welcome you to **make a tax deductible donation** to Kidney Kamp Foundation to help pay some of the \$600 cost for each camper.

Q: Who will take care of the medical needs of the campers?

A: Camp Shining Stars has a complete chronic kidney disease Health Center Unit to provide 24-hour care for the campers. The Health Center is staffed with nephrologists, nurses and a pharmacist. We will provide dialysis on-site. However, a nearby dialysis unit is available to provide hemodialysis treatments if necessary. A renal dietitian and a social worker are also available for consultation. Minor medical needs will be handled at the Health Center at camp. Nearby emergency facilities are available, if needed.

Q: How will my child get to camp and back home?

A: There are two options available: you can drive your child directly to camp on Sunday between 2 p.m. and 4 p.m. and pick him/her up on Friday no later than 9 a.m., or your child can ride the provided bus.

Q: Where will my child sleep?

A: The campers are assigned according to age to cabins with 10 to 11 other campers, along with trained adult and teen counselors. There are no co-ed cabins. The air conditioned cabins are equipped with fully accessible restrooms and showers.

Q: Can I call my child at camp?

A: We encourage parents to call the camp only in cases of emergency. Likewise, you will be notified immediately in the event of an emergency with your child. The phones at Camp For All are for the Staff use only and are not available for use by campers unless there is an emergency. *Please make every effort to enjoy your time away from your child. We will definitely make every effort for your child to enjoy their time away from you!*

Q: Can I see what camp looks like?

A: Yes. We encourage you to look at camp photos and videos from previous summers at www.facebook.com/kidneykampfoundation. We try to upload photos daily during Camp Shining Stars.

Should there be an emergency while your child is at camp, you may call (979) 289-3094. This number is for emergencies only! Any questions or comments that are non-emergencies may be directed to the Kidney Kamp Foundation office at (713) 500-5670.

We are looking forward to another great year at camp with your child(ren). If you have any questions about the camp, facilities or activities, please feel free to contact Dr. Joshua Samuels at the UT Houston Pediatric Nephrology Division at (713) 500-5670. **Remember: application packet is due by June 28, 2019 to:**

Camp Shining Stars

C/O UTHealth Pediatric Nephrology
6431 Fannin Street; MSB 3-121
Houston, TX 77030

You may fax completed application to (713) 500-5680

For help completing these forms, please contact Cindie Gammon at (713) 704-4886.
--

Thank You,

The Kidney Kamp Foundation

Participant's Last Name

Participant's First Name

2019 CAMP SHINING STARS



CHECKLIST

Parents: Keep this list to help you get your child ready for camp.

Due Friday, June 28, 2019

Mail the following signed documents:

- ☐ Camp application
- ☐ Consent/Release for liability, media, treatment, participation
- ☐ Authorization for Disclosure and Use of Protected Health Information
- ☐ Medical/Physical approval form completed by child's physician
- ☐ Copies of all insurance and immunization forms
- ☐ Online consent form at www.campforall.org

On August 4, 2019

Pack the following for camp. **LABEL ALL ITEMS WITH CAMPER'S NAME!**

- ☐ All medications in separate bag, labeled and in hand on the bus. DO NOT PUT MEDICATIONS IN LUGGAGE. ASK FOR PILLS, PLEASE!
- ☐ ALL Peritoneal Dialysis supplies (**including cycler!**) EVERYTHING!!!
- ☐ **Bedding** – sheets, pillow, pillowcase, blanket or sleeping bag
- ☐ Toiletries – soap and shampoo; toothbrush and toothpaste; hair brush/comb
- ☐ Hygiene Products – deodorant; feminine products
- ☐ **Towel**/wash cloth for showering
- ☐ Clothing – comfortable clothing such as shorts, t-shirts, active wear
- ☐ Long-sleeved shirts or sweatshirt, pants and jeans
- ☐ **Must have closed-toe shoes such as tennis shoes. Though boots are also allowed, camper must have rubber soled shoes!**
- ☐ Undergarments: underpants, bras and socks
- ☐ Swimsuit / swimming trunks / beach towel for pool
- ☐ Flashlight with extra batteries
- ☐ Sunscreen and bug repellent
- ☐ Glasses/contact lenses and necessary cases or solutions
- ☐ \$30 per rider for the bus
- ☐ Optional items: disposable camera

**ALL ELECTRONICS WILL BE CONFISCATED.
DO NOT BRING THEM TO CAMP!!!**

DO NOT BRING CELL PHONES, IPODS, LAPTOPS, VIDEO GAMES, RADIOS, BOOM BOXES, CD PLAYERS, PAGERS OR WEAPONS OF ANY TYPE—KNIVES, GUNS, ETC.



Participant's Last Name _____

Participant's First Name _____

2019 CAMP SHINING STARS

KIDNEY PATIENT APPLICATION



National
Kidney
Foundation™ of
Louisiana

KIDNEY PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Contact Number: _____ Preferred Gender: M F

Email Address: _____ Kidney Provider: Houston Louisiana

Date of Birth: _____ Age at time of camp: _____ Last grade completed: _____

T-shirt size: Youth S Youth M Youth L Adult Sizes: S M L XL XXL

Name of Sibling (if any) Attending Camp: _____

LEGAL PARENT OR GUARDIAN INFORMATION

Parent or Guardian's name: _____

Main Phone Number: _____ Alternate phone number: _____

We need to be able to contact you any time, day or night, if your child has a medical emergency.

EMERGENCY CONTACTS (Other than person above)

Emergency Contact Name #1: _____

Main Phone Number: _____ Alternate number: _____

Emergency Contact Name #2: _____

Main Phone Number: _____ Alternate phone number: _____

CAMP TRANSPORTATION (Houston Campers ONLY)

Arrival on August 4th

- ☐ I will drive this camper to Camp For All.
- ☐ This camper will ride the bus to camp.

Return on August 9th

- ☐ I will pick this camper up at Camp For All.
- ☐ This camper will ride the bus to Houston.

***There will be a \$30.00 fee to ride the bus. Bring it with you when you arrive to ride the bus.**

Participant's Last Name

Participant's First Name

INSURANCE INFORMATION

CSHCN? Y N CSHCN #: _____
Medicare?: Y N Medicare #: _____
Medicaid?: Y N Medicaid #: _____
Private Insurance Y N Group #: _____
Insurance Name: _____
Insurance Phone: _____
Prescription Plan Y N
Insurance Name: _____
Insurance Phone: _____
Comments: _____

***PLEASE INCLUDE A COPY OF ALL INSURANCE CARDS (FRONT AND BACK) INCLUDING PRESCRIPTION PLAN**

APPLICATION DEADLINE: June 28, 2019

Please send completed application, including consent/release forms to:

Camp Shining Stars
UT Houston Pediatric Nephrology
6431 Fannin St, MSB 3-121
Houston, TX 77030

or

Fax to (713) 500-5680

For help completing these forms, please contact Cindie Gammon at (713) 704-4886.

Consent and Release documents are located online this year. You MUST scan the code to visit the correct website and complete the online forms for each person participating in Camp Shining Stars.



2019 CAMP RELEASE FORMS

This form must be read, completed and signed online by parent/guardian before your child can attend Camp Shining Stars at Camp For All.

PARTICIPATION CONSENT

I understand and certify that my/my child's participation in **Camp Shining Stars** and its activities at Camp For All is completely voluntary. I have familiarized myself with **Camp Shining Stars** program and activities at Camp For All in which I/my child will be participating. I recognize that certain hazards and dangers are inherent in these activities, which may include, but not limited to, the activities of horseback riding, high and low elements ropes course, swimming, archery, riflery and canoeing. I acknowledge that although **Camp Shining Stars** and Camp For All have taken safety measures to minimize the risk of injury to camp participants, **Camp Shining Stars**, the Kidney Kamp Foundation, and Camp For All cannot insure or guarantee that the participants, equipment, premises or activities will be free of hazards, accidents or injuries. I recognize and have instructed my child in the importance of knowing and abiding by the rules, regulations, and procedures for **Camp Shining Stars** at Camp For All. Further, I have received approval from a doctor authorizing me/my child to participate in the **Camp Shining Stars** activities at Camp For All. I also agree to inform **Camp Shining Stars** of any activities in which I/my child may not participate.

LIABILITY RELEASE

I, the undersigned, understand that occasionally accidents occur during camp activities and that participants may sustain serious personal injury and property damages as a consequence thereof. Knowing the risks of camp activities, nevertheless, I agree to assume those risks and by signing this liability release, I intend to legally bind myself, my minor children, my heirs, executors, and administrators. I hereby release and forever discharge **Camp Shining Stars**, the Kidney Kamp Foundation, and Camp For All, and any of their officers, directors, employees, and agents from all claims, causes of action or damages arising out of any injury, illness, or loss of any kind, known or unknown, including but not limited to injuries to property or person, to me/my child during or related to my/my child's attendance at **Camp Shining Stars** at Camp For All.

MEDIA RELEASE

I hereby give **Camp Shining Stars**, the Kidney Kamp Foundation, and Camp For All the right to interview and/or to take photographs, audio or audio-visual recordings of me/my child to be used in promotional, educational, or fundraising materials including, but not limited to online, social media, videos, pamphlets and brochures. I understand my/my child's name may be used in connection with these materials. By signing this media release, I intend to legally bind myself, my minor children, my heirs, executors and administrators. **Camp Shining Stars**, the Kidney Kamp Foundation, and Camp For All shall have the right to use photographs or other images of me/my child in promotion, educational or fund-raising materials. I acknowledge that **Camp Shining Stars**, the Kidney Kamp Foundation, or Camp For All shall have all rights of copyright in and to such photographs and videos and may use such copyright fully. I also hereby release **Camp Shining Stars**, the Kidney Kamp Foundation, and Camp For All and its officers, agents and employees from all liability connected with the taking and use of these materials as is authorized by **Camp Shining Stars** and Camp For All. In addition, I waive all rights, interest or claims for payment in connection with any exhibition or release of these materials. This consent is voluntary, and I give it in the interest of public information, education, the furtherance of the goals of these institutions, or other lawful purposes. I acknowledge that I have legal authority to sign this form on behalf of the minor whose name is mentioned above.

Consent and Release documents are located online this year. You MUST scan the code to visit the correct website and complete the online form.



Scan me

Participant's Last Name

Participant's First Name

All forms must be completed and signed by parent or guardian before child will be admitted to camp.

CONSENT FOR TREATMENT

I authorize the **Camp Shining Stars** Camp Medical Director and Medical Staff to care for my child, administer any emergency care, and perform any therapeutic or diagnostic procedures that may be advisable for the patient's well being. No warranty or guarantee has been made as to result or cure.

If my child is on dialysis, I am aware of the risks which include but are not limited to infection and low blood pressure and that these may occur at camp. I understand that I may contact **Camp Shining Star's** Medical Director and Medical Staff through the UT Pediatric Nephrology Office at (713-500-5670) if I have any questions concerning medical issues at camp.

If my child is on peritoneal dialysis, I am familiar with the technique of Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycler Peritoneal Dialysis (CCPD) and I am aware of the risks which include but are not limited to infection and low blood pressure and that these may occur at camp. I understand that I may contact **Camp Shining Star's** Medical Director and Medical Staff through the UT Pediatric Nephrology Office at (713-500-5670) if I have any questions concerning medical issues at camp.

I understand that if a medical emergency arises with my child, he/she may be transported to an appropriate hospital and treatment started while I am being contacted. The person I have designated as emergency contact will be notified as soon as possible in the event of an emergency.

I understand that health insurance will NOT be provided by **Camp Shining Stars**, the National Kidney Foundation of Louisiana, the Kidney Kamp Foundation, nor Camp for All. All cost incurred during emergency treatment will be my responsibility.

Parent or Guardian's Signature: _____ Date: _____

Parent or Guardian's Printed Name: _____

I have reviewed the behavioral expectations with the camper.

I agree to inform the camp of any activities that my child may NOT participate in.

My child may participate in all activities. ☐

The activities that my child may not participate in are as follows:

Parent or Guardian's Signature: _____

Date: _____

Participant's Last Name

Participant's First Name



National
Kidney
Foundation™ | of
Louisiana

Authorization for the Disclosure and Use of Protected Health Information

In order for your child to attend Camp Shining Stars, you must sign this authorization. Because of your child's health condition, it is important for the individuals working at the Camp (the "Camp Staff") to know about your child's health condition so that they can make informed decisions about your child's ability to participate in Camp programs and activities. Accordingly, the purpose of this authorization is to allow Camp Shining Stars to disclose protected health information about your child to the Camp Staff. Sharing this information with the Camp Staff will help ensure that your child's needs and limits are recognized and enhance your child's participation in the Camp's programs and activities.

1. I authorize **Camp Shining Stars** to use and disclose protected health information about my child from my child's medical record(s), if necessary:
Child's Name: _____
Birth Date: _____
Social Security No.: _____
2. Information from the following records may be used and disclosed:
_____ Child's Complete Medical Records; or
_____ Other: _____ (specifically identify)
3. I understand and agree that this authorization of disclosure of my child's protected health information includes disclosure of information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care, if applicable.
4. I understand and agree that my child's protected health information will be used and disclosed to the Camp Staff including **Camp Shining Stars'** Medical Directors, staff, and volunteer counselors and the Camp For All Foundation work force.
5. I understand that once my child's authorized protected health information is given to individuals working at the Camp, then my child's protected health information may no longer be protected by federal and Texas privacy laws and could possibly be re-disclosed by individuals working at the Camp to someone else. In order to protect the confidentiality of protected health information, however, the agreement between **Camp Shining Stars** and the Camp requires the Camp Staff to maintain the confidentiality of protected health information.
6. I understand that my child's ability to obtain treatment as a patient from **Camp Shining Stars** is not conditioned on signing this authorization. Rather, I understand that this authorization is required, and the disclosure of my child's protected health information is required, in order to allow my child to attend the Camp and participate in the Camp's programs and activities.

Participant's Last Name

Participant's First Name

Authorization for the Disclosure and Use of Protected Health Information

7. I understand that I may revoke this authorization in writing at any time, except to the extent that **Camp Shining Stars** has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to **Camp Shining Stars** Medical Director Joshua Samuels, Camp Director, 6431 Fannin St, MSB 3-121, Houston, Texas 77030. Phone: 713-500-5670; Fax: 713-500-5680.
8. Unless otherwise revoked, I understand and agree that this authorization expires two years after my child's participation in **Camp Shining Stars** ends.

Printed Name of Child: _____

Signature of Child's Parent/Guardian: _____

Printed Name of Child's Parent or Guardian: _____

Date of Signature: _____

Participant's Last Name

Participant's First Name

2019 Camper Profile Sheet

This form will help us get to know your child and aid our counselors in preparing to welcome him/her at Camp Shining Stars. Your cooperation in honestly completing these questions will help us ensure that your child will have the best possible experience, both during scheduled camp activities and while in the cabin. Please be assured that this form is confidential and will only be reviewed by camp staff and your child's counselors.

Name camper goes by: _____ Birthday: _____ Grade entering in Fall: _____

1. Has your child ever attended sleep-away camp before? _____ Number of years? _____

2. Does your camper live with both parents? _____ If not, with whom? _____

3. Number of siblings? _____ Ages: _____

4. Place an "X" on the line graph where it best describes your child:

EXAMPLE: Shy |-----X-----| Outgoing

Shy	-----	Outgoing
Not active	-----	Active
Easily upset	-----	Not easily upset
Aggressive	-----	Passive
Leader	-----	Follower
Extrovert	-----	Introvert

5. My camper has ADHD, behavior problems, or emotional problems: _____

6. My camper's hobbies and interests include: _____

7. My camper has concerns and fears relating to the following areas: _____

8. My camper IS / IS NOT a bedwetter. (Please provide details if possible). _____

9. My expectations for my camper during his/her week of camp are: _____

10. What else should we know about your camper in order to be sensitive to his/her needs? (recent family deaths, discipline, family issues, religious background, etc.) _____

Participant's Last Name

Participant's First Name

2019 Camp Shining Stars

Kidney Patient Medical Application/Physical Form

Each camper must have a completed medical application submitted by June 28, 2019. A physical examination must be performed within 6 months before camp. You may attach written medical history or any documentation that will help in giving your child the best care.

Please ask your Kidney specialist to send a copy of your most recent medical report, including medication lists and allergies.

To Be Completed By Parent or Guardian:

Camper Last Name: _____ Camper First Name _____

Date of Birth: _____ Age: _____ Preferred Gender: M F

Primary Care Physician _____ Office Phone Number _____

Nephrologist: _____ Office Phone Number _____

Immunizations: Please send a copy of current immunization record with this form.

General Medical History

	yes	no		yes	no		yes	no
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	Behavior Issues	<input type="checkbox"/>	<input type="checkbox"/>			

Details of any YES answer: _____

Participant's Last Name

Participant's First Name

Medical Application/Physical Form

To Be Completed by Physician (Nephrologist or Primary Care), PA or Nurse Practitioner

Allergies: NKDA (circle) or

Please include a copy of a recent H & P or progress note.

Underlying Kidney Disease: _____ Date of Dx: _____

ESRD: Y N (circle one) Hemodialysis Peritoneal Dialysis Transplant

Brief Treatment History: _____

**Please ask your Doctor to convert ALL medication to pill/tablets for the week.
Liquid medicines are NOT preferred!!! Medicine dispensed 4 times a day.**

Medication Name	Strength	Dose	Schedule
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Physical Examination

Date of exam: _____

Height _____ Weight _____ BP _____ / _____ P _____

I have reviewed this child's medical history and have examined this child and I:

_____ approve participation in camp with no limitations

_____ approve participation in camp with the following limitations _____

Practitioner's Signature _____ Date _____

Print Name _____ Phone #: _____



2019 CAMP SHINING STARS SIBLING APPLICATION

SIBLING CAMPER INFORMATION

Last Name: _____ First Name: _____ MI: _____

Name of Kidney Patient Accompanying at Camp: _____

Preferred Phone Number: _____ Preferred Gender: M F

Email Address: _____

Date of Birth: _____ Age at time of camp: _____ Last grade completed: _____

T-shirt size: Youth S Youth M Youth L Adult Sizes: S M L XL XXL

LEGAL PARENT OR GUARDIAN INFORMATION

Parent or Guardian's name: _____

Main Phone Number: _____ Alternate phone number: _____

Email address: _____

***We need to be able to contact you any time, day or night, if your child has a medical emergency.**

EMERGENCY CONTACTS

Emergency Contact Name #1: _____

Primary Phone Number: _____ Alternate Phone number: _____

Emergency Contact Name #2: _____

Primary Phone Number: _____ Alternate phone number: _____

CAMP TRANSPORTATION (Houston Campers ONLY)

Arrival on August 4th

- ☐ I will drive this camper to Camp For All.
- ☐ This camper will ride the bus to camp.

Return on August 9th

- ☐ I will pick this camper up at Camp For All.
- ☐ This camper will ride the bus to Houston.

***There will be a \$30.00 fee to ride the bus. Bring it with you when you arrive to ride the bus.**

Participant's Last Name

Participant's First Name

Sibling Camper Application

INSURANCE INFORMATION

CSHCN? Y N CSHCN #: _____
Medicare?: Y N Medicare #: _____
Medicaid?: Y N Medicaid #: _____
Private Insurance Y N Group #: _____
Insurance Name: _____
Insurance Phone: _____
Prescription Plan and Number: _____
Comments: _____

*** INCLUDE COPIES OF BOTH SIDES OF ALL INSURANCE CARDS**
***** INCLUDING PRESCRIPTION PLAN**

APPLICATION DEADLINE: June 28, 2019

Please send completed application to:

Camp Shining Stars
Pediatric Nephrology & Hypertension
6431 Fannin St, MSB 3-131
Houston, TX 77030

For application aid, please contact Cindie Gammon at (713) 704-4886.

Consent and Release documents are located online this year. You MUST scan the code to visit the correct website and complete the online form for each person participating in Camp Shining Stars.



Participant's Last Name

Participant's First Name

(The actual participant's name, not the kidney patient)

All forms must be completed and signed by parent or guardian before child will be admitted to camp.

CONSENT FOR TREATMENT

I authorize the **Camp Shining Stars** Camp Medical Director and Medical Staff to care for my child, administer any emergency care, and perform any therapeutic or diagnostic procedures that may be advisable for the patient's well-being. No warranty or guarantee has been made as to result or cure.

I understand that if a medical emergency arises with my child, he/she may be transported to an appropriate hospital and treatment started while I am being contacted.

I understand that health insurance will NOT be provided by **Camp Shining Stars**, the National Kidney Foundation of Louisiana, the Kidney Kamp Foundation, nor Camp for All. All cost incurred during emergency treatment will be my responsibility.

Parent or Guardian's Signature: _____ Date: _____

Parent or Guardian's Printed Name: _____

I have reviewed the behavioral expectations with the camper.

I agree to inform the camp of any activities that my child may NOT participate in.

My child may participate in all activities. ☐

The activities that my child may not participate in are as follows:

Parent or Guardian's Signature: _____

Date: _____

Participant's Last Name

Participant's First Name

(The actual participant's name, not the kidney patient)



Authorization for the Disclosure and Use of Protected Health Information

In order for your child to attend Camp Shining Stars, you must sign this authorization. Because of your child's health condition, it is important for the individuals working at the Camp (the "Camp Staff") to know about your child's health condition so that they can make informed decisions about your child's ability to participate in Camp programs and activities. Accordingly, the purpose of this authorization is to allow Camp Shining Stars to disclose protected health information about your child to the Camp Staff. Sharing this information with the Camp Staff will help ensure that your child's needs and limits are recognized and enhance your child's participation in the Camp's programs and activities.

1. I authorize **Camp Shining Stars** to use and disclose protected health information about my child from my child's medical record(s), if necessary:
Child's Name: _____
Birth Date: _____
Social Security No.: _____
2. Information from the following records may be used and disclosed:
_____ Child's Complete Medical Records; or
_____ Other: _____ (specifically identify)
3. I understand and agree that this authorization of disclosure of my child's protected health information includes disclosure of information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care, if applicable.
4. I understand and agree that my child's protected health information will be used and disclosed to the Camp Staff including **Camp Shining Stars'** Medical Directors, staff, and volunteer counselors and the Camp For All Foundation work force.
5. I understand that once my child's authorized protected health information is given to individuals working at the Camp, then my child's protected health information may no longer be protected by federal and Texas privacy laws and could possibly be re-disclosed by individuals working at the Camp to someone else. In order to protect the confidentiality of protected health information, however, the agreement between **Camp Shining Stars** and the Camp requires the Camp staff to maintain the confidentiality of protected health information.
6. I understand that my child's ability to obtain treatment as a patient from **Camp Shining Stars** is not conditioned on signing this authorization. Rather, I understand that this authorization is required,

Participant's Last Name

Participant's First Name

(The actual participant's name, not the kidney patient)

and the disclosure of my child's protected health information is required, in order to allow my child to attend the Camp and participate in the Camp's programs and activities.

7. I understand that I may revoke this authorization in writing at any time, except to the extent that **Camp Shining Stars** has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to **Camp Shining Stars** Medical Director Joshua Samuels, Camp Director, 6431 Fannin St, MSB 3-121, Houston, Texas 77030. Phone: 713-500-5670; Fax: 713-500-5680.
8. Unless otherwise revoked, I understand and agree that this authorization expires two years after my child's participation in **Camp Shining Stars** ends.

Printed Name of Child: _____

Signature of Child's Parent/Guardian: _____

Printed Name of Child's Parent or Guardian: _____

Date of Signature: _____

Participant's Last Name

Participant's First Name

(The actual participant's name, not the kidney patient)

2019 Sibling Profile Sheet

This form will help us get to know your child and aid our counselors in preparing to welcome him/her at Camp Shining Stars. Your cooperation in honestly completing these questions will help us ensure that your child will have the best possible experience, both during scheduled camp activities and while in the cabin. Please be assured that this form is confidential and will only be reviewed by camp staff and your child's counselors.

Name this camper goes by: _____ Birthday: _____ Grade entering in Fall: _____

1. Has your child ever attended sleep-away camp before? _____ Number of years? _____

2. Does your camper live with both parents? _____ If not, with whom? _____

3. Number of siblings? _____ Ages: _____

4. Place an "X" on the line graph where it best describes your child:

EXAMPLE: Shy |-----X-----| Outgoing

Shy	-----	Outgoing
Not active	-----	Active
Easily upset	-----	Not easily upset
Aggressive	-----	Passive
Leader	-----	Follower
Extrovert	-----	Introvert

5. My camper has ADHD or emotional problems (explain): _____

6. My camper's hobbies and interests include: _____

7. My camper has concerns and fears relating to the following areas: _____

8. My camper IS / IS NOT a bed-wetter. (Please provide information if possible). _____

9. My expectations for my camper during his/her week of camp are: _____

10. What else should we know about your camper in order to be sensitive to his/her needs? (recent family deaths, discipline, family issues, religious background, etc.) _____

Participant's Last Name

Participant's First Name

(The actual participant's name, not the kidney patient)

Sibling Medical Application/Physical Form

Each camper must have a completed medical application submitted by June 28, 2019.

A physical examination must be performed within 12 months before camp.

To Be Completed By Parent or Guardian:

Sibling Last Name: _____ Sibling First Name _____

Date of Birth: _____ Age: _____ Sex: M F

Primary Care Physician _____ Office Phone Number _____

Immunizations: Please send a copy of current immunization record with this form

To Be Completed by Physician, Physician Assistant or Nurse Practitioner

Allergies:

General Medical History:	yes	no	yes	no		yes	no	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	Behavior Issue	<input type="checkbox"/>	<input type="checkbox"/>			

Explain YES answers: _____

Medications: (name, dose, frequency)

Physical Examination

Height _____ Weight _____ BP _____ P _____

Vision: Normal Glasses Contacts (circle one)

Hearing: Normal Abnormal (circle one) Explain: _____

	N	Abn		N	Abn		N	Abn
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Neuro	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>

Explain abnormal: _____

I have reviewed this child's medical history and have examined this child and I:

_____ approve participation in camp with no limitations

_____ approve participation in camp with the following limitations _____

_____ deny participation in camp because _____

Practitioner's Signature _____ Date _____

Print Name _____ Office Phone: _____