



Dear Parent/Guardian:

Camp Boggy Creek is now accepting applications for our Spring Kids on Ventilation Assisted Camp (KOVAC) Family Weekend Retreat (a Wednesday to Sunday event) **March 16-20, 2011!**

This weekend will be filled with song and dance, arts and crafts, boating and fishing, swimming and many other activities from which to choose. There is **no charge** to your family to attend Camp Boggy Creek.

Our camp is for KOVAC campers between the ages of 7 and 21; siblings can be of any age. The weekend is for **Immediate family members** living in the household. Your home health care is also invited to join us should you need their assistance.

If you are interested in attending, please fill out the enclosed application and ask your child's doctor to complete the Medical Form. The application selection is **February 17th, late applications will be accepted for review; however you might start out on the waitlist.** You will be notified by email if email address is provided. Those without email will be notified via home address after February 17th.

Even though we would like to accept all who apply, our spaces are unfortunately limited. Factors including severity of illness and number of times of attendance at one of our camping sessions are considered.

Please mail your completed Application to:

Mary Parrish
Camper Recruitment Coordinator
Camp Boggy Creek
30500 Brantley Branch Road
Eustis, Fl. 32736

If you have any questions please feel free to contact Mary at 352-483-4200 ext. 252, Mary@BoggyCreek.org



KOVAC Family Retreat Application

March 16-20, 2011

30500 Brantley Branch Road
Eustis, FL 32736
Phone: (352) 483-4200 ext. 252 or 276

Camper Name _____ Age _____ Birth-date _____ M _____ F _____

Mailing address _____

City _____ State _____ Zip _____ County _____

Email address _____

Phone numbers (include area code): Home _____

Cell _____ Work _____

(We must have a current phone number and address for camp)

Please print below family members attending (do not include camper name)

Parent _____ Age _____ Sex _____ Relationship _____

Medical Condition (if any): _____

Parent _____ Age _____ Sex _____ Relationship _____

Medical Condition (if any): _____

Name _____ Age _____ Sex _____ Relationship _____

Medical Condition (if any): _____

Name _____ Age _____ Sex _____ Relationship _____

Medical Condition (if any): _____

Name _____ Age _____ Sex _____ Relationship _____

Medical Condition (if any): _____

Name _____ Age _____ Sex _____ Relationship _____

Medical Condition (if any): _____

Does your family need an interpreter? Yes _____ No _____ If so what language _____

Specialty Doctor's Name _____ **Institution** _____ **Phone** _____

CAMPER MEDICAL INFORMATION

Please list any medical conditions, considerations, and/or limitations: _____

Food Allergies _____ Drug Allergies _____

Parent/Guardian Consent Form

I, undersigned parent/guardian give my consent for my family to participate in any and all activities including but not limited to: swimming, boating and fishing, horseback riding (horseback riding is not offered at every retreat), unless stated otherwise. I also give Camp Boggy Creek (CBC), session sponsors and selected news media permission to photograph and use pictures, video or audio tapes of my family either alone or in a group for news letters, fund-raising activities, bulletin board, camp album or use in public understanding and support of programs for chronically ill children. CBC respects the privacy of its campers and their family and does not allow unauthorized visitors to photograph the camp or its campers.

In the event that any medical needs or medical emergency should arise while at camp, I, undersigned Parent/Guardian hereby grants permission to the medical, other staff, and consulting physician at The Boggy Creek Gang, Inc., an IRS 501(c)(3) charitable organization, to administer medication and provide medical and other care for my family, including, without limitation, any medical emergency care required. I also hereby give my consent for any transportation deemed necessary or appropriate, in the sole discretion of CBC, in connection with the treatment of my child/family. I also assume full financial responsibility for any and all medical and other expenses incurred for or on behalf of my family while at CBC or offsite if in connection with medical treatment, and acknowledge, agree, and understand that CBC shall not be liable for any such expenses.

I, the undersigned parent/guardian assume full financial responsibility for any damage or destruction of camp property as a result of the actions of my family, and understand that I may be billed for any such damage or destruction.

I fully understand and agree to the terms stated above and agree that all information is complete and correct to the best of my knowledge.

Do not let my child/family participate in _____

Parent/Guardian Signature

_____/_____/_____

Date

Please print name of Parent/Guardian

Please add any information or instructions about your family you would like us to know to do our job better or to make your stay more enjoyable.

Ventilation Assisted Camp

Campers Name: _____

Ventilator Dependent? Yes ___ No _____ If yes, complete next section:

When did child become ventilator dependent? : _____

Hours per day on ventilator: _____

Type of ventilator: _____

Current ventilator settings: _____

Frequency of circuit changes: _____

Company/Therapist servicing ventilator: _____

Address (of company/therapist): _____

Phone: (_____)

Tracheotomy? Yes _____ No _____ If yes:

Suctioning frequency:

Type/Size: _____

Changing frequency: _____

Oxygen? Yes _____ No _____ If yes:

System currently used: Liquid _____ Gas _____ Concentrator _____

List flow: _____ Hours per day: _____

Respiratory Treatments (if any)

Type:

Dose/Frequency:

Campers name: _____

Feeding:

Feeds orally? Yes _____ No _____

If Yes: Table food _____ Soft _____ Pureed _____ Other: _____

Gastrosotomy? Yes _____ No _____

If Yes:

Type/Size: _____

Formula/Diet: _____

Elimination:

Bowel/Bladder control? Yes _____ No _____

Requires catheterization? Yes _____ No _____ If yes:

Frequency: _____ Type/Size: _____

OTHER PHYSICIANS, NURSES, OR RESP. THERAPIST INVOLVED IN CHILDS CARE:

Name: _____ Specialty: _____

Agency: _____

Street: _____ Phone (_____) _____

City: _____ State: _____ Zip: _____

Childs Mobility:

If needs wheelchair: Manual: _____ Electric: _____

Position in wheelchair: Upright: _____ Reclined: _____

Paraplegic: _____ Quadriplegic: _____

Comments: _____

Communication:

Does Child Communicate? Yes No Verbally? Yes No

Comments: _____

If no, what alternative forms of communication does he or she use? _____

Childs Educational Experience:

Home-bases: _____ School setting: _____ Both: _____

Indicate current grade level and/or comment on type of classroom setting: _____

Is child receiving physical, occupational or other special therapy? If yes:

Type of therapy: _____

Contact person: _____

Agency: _____

Street address: _____ Phone: (_____) _____

City: _____ State: _____ Zip Code: _____

Has child ever been away from home/hospital over night? If yes:

Please describe the occasion: _____

Describe Childs recreational activities and personal interests: _____

How do you think your ventilation assisted child and your family would benefit from this Program? _____

MEDICAL FORM

Must be completed and signed by **Physician**

Camper's Name: _____ DOB: _____ Wt.: _____

Primary Diagnosis: _____

Other Diagnoses: _____

Allergies: _____

Please describe any **current medical problems**. _____

PHYSICAL EXAM significant findings _____

This child may interact with animals at the Camp petting farm Yes No

MEDICATIONS

Name: _____ Dose: _____ Route: _____ Frequency: _____

Is the child's development appropriate for his/her age? Yes No

If no, at what age does s/he function? _____

Are there any behavior problems that would affect child's participation in a group? _____

Pertinent Psychosocial Information _____

Physician's Statement: I have examined this child and find him/her physically able to attend camp. I understand that the above Treatment Plan will be followed at camp, unless other orders are received.

Please send a copy of the most recent **OFFICE NOTE** and a copy of the IMMUNIZATION RECORD.

Signature of Physician

Print Name

Date

Hospital, Treatment Center

Emergency #

Fax #

Physician email address

