

**2009 Camper Application**

(please include a photograph)

NAME \_\_\_\_\_

What would you like to be called at camp? \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ COUNTY \_\_\_\_\_

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

MOTHER'S NAME AND ADDRESS \_\_\_\_\_

MOTHER'S HOME PHONE NUMBER ( ) \_\_\_\_\_ WORK NUMBER ( ) \_\_\_\_\_

FATHER'S NAME AND ADDRESS \_\_\_\_\_

FATHER'S HOME PHONE ( ) \_\_\_\_\_ WORK NUMBER ( ) \_\_\_\_\_

CHILD'S DIAGNOSIS (if any) \_\_\_\_\_

Can your child swim? \_\_\_\_\_ Needs a life jacket? \_\_\_\_\_

Does your child have any specific fears (of the dark, of thunder, of water, etc)? Please explain:

Describe any unusual bedtime or sleep habits (bedwetting, sleepwalking, nightmares, etc.):

NAME OF PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME \_\_\_\_\_ PHONE NUMBER ( ) \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

FOR CHECK-IN USE	
T/P/R/BP	
Weight	
Skin	
HEENT	
Exposures	
Misc	

### 2009 MEDICAL HISTORY

**NAME** \_\_\_\_\_ **AGE** \_\_\_\_\_ **BIRTHDATE** \_\_\_\_\_

**HOME ADDRESS** \_\_\_\_\_

**HOME PHONE** (\_\_\_\_) \_\_\_\_\_ **PARENTS WORK PHONE** (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION** (in case of medical emergency)

NAME OF INSURANCE COMPANY \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

MEDICAID NUMBER \_\_\_\_\_ CIDC NUMBER \_\_\_\_\_

**DIAGNOSIS** (if any) \_\_\_\_\_ **Still getting chemotherapy?** \_\_\_\_\_

**OTHER MEDICAL CONDITIONS** (asthma, seizures, etc.) \_\_\_\_\_

**ALLERGIES** (medicines, insect bites, foods, etc.) \_\_\_\_\_

**CURRENT MEDICINES** (you must send a one-week supply to camp with your child):

NAME OF MEDICINE	AMOUNT	TIMES GIVEN	OTHER INFO

**SPECIAL EQUIPMENT?** (wheelchair, Port-a-cath, contact lenses, crutches, etc.)

\_\_\_\_\_

Camper Name \_\_\_\_\_

List any diet restrictions: \_\_\_\_\_

List any activity restrictions (for example - no swimming, no sports). Give reason for each:  
\_\_\_\_\_

**★ PLEASE NOTE:** The following information about chicken pox and immunizations is VERY IMPORTANT!!! **Do not leave anything blank.**

Has your child had chicken pox? \_\_\_\_\_

In the past 4 weeks, has your child been exposed to anyone with chicken pox? \_\_\_\_\_

In the past 4 weeks, has your child received VZIG (shot to protect against chicken pox)? \_\_\_\_\_

Please give the dates of the most recent shot for these immunizations:

Tetanus \_\_\_\_\_ MMR \_\_\_\_\_ DPT / DT / Td \_\_\_\_\_

**IN CASE OF EMERGENCY, LIST 2 PERSONS WE CAN CALL ( give phone number)**

1. NAME: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_

2. NAME: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_

I hereby grant the medical staff of The Rainbow Connection permission to administer routine care and medication to my child as well as any emergency care that is required. I understand that I will be notified as soon as possible in the event of an emergency.

\_\_\_\_\_  
**SIGNATURE OF PARENT**

\_\_\_\_\_  
**DATE**

**PHYSICIAN'S STATEMENT:** It is my opinion that this child is physically able to engage in camp activities, except as previously noted. I have verified that the information on health, medicines, and immunizations is correct.

\_\_\_\_\_  
SIGNATURE OF PHYSICIAN

\_\_\_\_\_  
DATE



## 2009 Consent Form

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Camper/Counselor Name

I understand and certify that my/my child's participation is completely voluntary in The Rainbow Connection, the summer camp program sponsored by The Rainbow Connection and its activities at Camp For All. I have familiarized myself with The Rainbow Connection 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 are not limited to the activities of horseback riding, high and low elements ropes course, swimming, archery, and canoeing. I acknowledge that although The Rainbow Connection and Camp For All have taken safety measures to minimize the risk of injury to camp participants, The Rainbow Connection and Camp For All cannot insure or guarantee that the participants, camp 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 of The Rainbow Connection at Camp For All. Further, I have received approval from a doctor authorizing me/my child to participate in The Rainbow Connection Activities at Camp For All. I also agree to inform The Rainbow Connection of any activities in which I/my child may not participate.

I hereby grant the medical staff of The Rainbow Connection permission to administer routine care and medication to me/my child as well as any emergency care that is required. I understand that I will be notified as soon as possible in the event of an emergency.

I, the undersigned, understand that occasionally accidents occur during camp activities and that participants may sustain 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 The Rainbow Connection and Camp For All and any of their officers, directors, employees, and agents from all claims, causes of action or damages arising out 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 The Rainbow Connection at Camp For All.

I give The Rainbow Connection and Camp For All the right to interview and/or 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 videotapes, 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. The Rainbow Connection and Camp For All shall have the right to use the photographs or other images of me/my child in promotion, educational or fundraising materials. I acknowledge that The Rainbow Connection or Camp For All shall have all rights of copyright in and to such photographs and videotapes and may use such copyright fully. I also hereby release The Rainbow Connection and Camp For All and their officers, agents, and employees from all liability connected with taking and using these materials as authorized by The Rainbow Connection and Camp For All. In addition, I waive all rights, interest, or claims for payment in connection with any information, education, the furtherance of the goals and 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.

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Signature/Mother/Father/Guardian

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Date

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Signature of Camper/Counselor

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Date

UTMB USE ONLY: Please check one: \_\_\_\_\_ HIM to release PHI \_\_\_\_\_ PHI already has been released; HIM to only file Authorization

**AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) By UTMB**

**Patient Name:** \_\_\_\_\_  
Last First M.I. (Previous Or Other Names Used)

**Address:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **UH Number:** \_\_\_\_\_

If this Authorization is for any purpose other than the release of PHI for personal reasons, please state the purpose below:

I authorize the release of medical records from: \_\_\_\_\_  
The University of Texas Medical Branch  
301 University Blvd. Galveston, Texas 77555

Please release requested medical records to: Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

I specifically authorize the use and disclosure of the following PHI: **(Please provide a detailed description of the particular data and period of time you are requesting)**

- |  |  |
|--|--|
| <input type="checkbox"/> Emergency Records _____ | <input type="checkbox"/> Hospital Records _____  |
| <input type="checkbox"/> Clinic Records _____    | <input type="checkbox"/> Radiology Reports _____ |
| <input type="checkbox"/> Lab Reports _____       | <input type="checkbox"/> Radiology Films _____   |
| <input type="checkbox"/> Shot Records _____      | <input type="checkbox"/> Pathology Reports _____ |
| <input type="checkbox"/> Slides _____            | <input type="checkbox"/> Other _____             |

This authorization will expire on the 180<sup>th</sup> day of the signing unless a lesser date is specified below:

By signing this Authorization Form, I understand that I am giving my authorization for UTMB to use and/or disclose my protected health information (PHI) as described above. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care. If you are requesting psychotherapy session notes maintained by a mental health provider, a separate authorization form must be completed. I understand that I may revoke this authorization at any time by notifying UTMB in writing to the Health Information Management Department, 301 University Blvd, Galveston, Texas 77555-0782 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by UTMB before UTMB received my written notice of revocation. If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization Form. I understand that I am not required to sign this Authorization Form in exchange for the patient receiving treatment from UTMB.

\_\_\_\_\_  
**Signature of Patient or Authorized Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship to the Patient** (If signed by a Personal Representative)

IF PATIENT ID CARD IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

**AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) BY UTMB**

Medical Record Form 7032-Rev.5/05  
**The University of Texas Medical Branch Hospitals  
Galveston, Texas**

Original-Medical Record

UTMB FORMS MGT. STRICTLY PROHIBITS CHANGES TO THIS FORM.