The Hemophilia Foundation of Northern California

PLEASE FILL OUT ONE PER PERSON

Family Camp 2019 (January 18, 19, 20)

Camper Application

WE LOOK FORWARD TO SEEING YOU IN JANUARY. PLEASE FILL OUT THE APPLICATION BELOW (BOTH SIDES). IF YOU HAVE ANY QUESTIONS PLEASE CALL THE OFFICE: 510-658-3324 OR EMAIL BRYAN ANDERSON, HFNC COMMUNITY COORDINATOR, BRYAN.ANDERSON@HEMOFOUNDATION.ORG

SEND THE APPLICATIONS IN (ONE PER SERPSON) VIA THE WEBSITE, EMAIL, FAX, OR MAIL BY NOVEMBER 23, 2018.

Contact information

First Name: _____ **Last Name:** _____

Address: _____

Day phone: _____ **Cell phone:** _____

E-mail: _____ **Company:** _____

Emergency contact - persons to be contacted in the event of an emergency

First name	Last name	Relationship	Day phone	Cell phone
First name	Last name	Relationship	Day phone	Cell phone

Camp Arroyo is wheelchair accessible

For special assistance, please explain, (e.g. crutches, wheelchair, difficulty walking, etc.):

_____

Language of preference:

English ☐ **Spanish** ☐ **other:** _____

Please sign below before turning in. An unsigned form will be returned to you for your signature.

I understand there is an administrative fee for all campers of $25 (waiver available). I understand that the Hemophilia Foundation of Northern California may use my (my children's) photo in its newsletter, Facebook posts, or other media/marketing outlets.

Signature: _____ Date: _____

PLEASE SEE REVERSE, MORE INFORMATION NEEDED

Hemophilia Foundation of Northern California
6400 Hollis Street, Suite 6 • Emeryville, CA 94608 • Phone: 510.658.3324

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Medical information

First name:_____ **Last name:**_____ **Age:**_____

Male☐ **Female**☐ **Bleeding disorder:** **Yes**☐ **No**☐ If yes: Severe ☐ Moderate ☐ Mild ☐

Primary Care Physician

_____

Name of Hematologist / Physician **Address** **Phone**

_____

Hemophilia Treatment Center / Physician's Affiliation **Phone**

ALLERGIES…, ALLERGIES.., ALLERGIES

Food allergies: **Yes**☐ **No**☐ **if yes, list here 1**_____ **2** _____

Drug allergies: **Yes**☐ **No**☐ **if yes, list here 1**_____ **2** _____

DIETARY NEEDS, please explain, (e.g. vegetarian, lactose free, vegan, etc.):

_____

Medical conditions

Do you have any medical conditions? **Yes** ☐ **NO** ☐ If yes, explain below:

_____

Medications

_____

Drug name and strength Dose Frequency

_____

Drug name and strength Dose Frequency

_____

Drug name and strength Dose Frequency

Bleeding disorder diagnosis *I do not have a bleeding disorder* ☐

Factor VIII deficiency ☐ Factor IX deficiency ☐ Carrier VIII ☐ Carrier IX ☐

Von Willebrand Disease: Type I ☐ Type II ☐ Type II B ☐ Type III ☐

Factor activity level: _____% Other factor deficiency (type): _____

Platelet dysfunction: _____ Immune tolerance: _____

Inhibitor: Yes☐ **No**☐ **Inhibitor titer**: **Yes**☐ **No**☐ Date of last inhibitor test: _____

Treatment

What brand of factor is used? _____ Numbers of units usually used: _____

Do you have allergies to clotting products? **Yes**☐ **No**☐ If yes, what product? _____

Target joints: _____

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