



Family Camp 2019 (January 18, 19, 20)

VOLUNTEER APPLICATION

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
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Camp Arroyo is wheelchair accessible

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

Language of preference:

English ☐

Spanish ☐

other: _____

Skills, interests, talents or hobbies (musical instruments, crafts, first aid/cpr, dance, languages, etc.)

1. _____ 2. _____

3. _____ 4. _____

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 (including staff) of \$25. I understand that the Hemophilia Foundation of Northern California may use my photo in it's 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

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: _____