**Texas Children’s Hospital Food Allergy Camp at Camp Blessing**

Brenham, TX

March 13-15, 2020

**Food Allergy Camp:**

Texas Children’s Hospital Food Allergy Camp is a 2-night 3-day overnight camp that will be free of the top 8 allergens. Campers will have the opportunity to learn more about food allergies, connect with other kids, and participate in camp activities. The agenda will be provided to the parents at a later date.

**Staff:**

The Food Allergy Camp is staffed by Texas Children’s Hospital professionals and Camp Blessing camp counselors

* Camp Director-Dr. Sara Anvari
* Camp Co-Director-Daisy Tran, RN
* Camp Dietician-Lauren Kronisch, RD
* Camp Medical Staff- Ashley Reiland, FNP; Sara Anvari, MD, MS and Daisy Tran, RN
* Other staff: dieticians, dietetic interns, and Texas Children’s Hospital Staff Members.
* Daytime counselor: Camp Blessing staff
* Nighttime counselor: Texas Children’s Hospital staff members
* Junior co-counselors: older participants diagnosed with food allergies may be chosen by the camp committee to take a leadership role at camp

**Arrival and Departure:**

We ask for campers to be dropped off at Camp Blessing on Friday, March 13th at 2pm and picked up on Sunday, March 15th at 11am. Parents/guardians will have the opportunity to meet the staff and tour the facility upon arrival.

**Meals:**

Meals will be free of the top 8 allergens and tailored to meet each camper’s dietary needs. Campers will be provided with 5 meals and multiple snack times throughout their stay.

**Housing:**

The air-conditioned cabin consists of housing for 28 campers and 4 night-time counselors. There is a girls and boys corridor with separate bathrooms. Each corridor has two rooms with 8 bunk beds each.

**Activity:**

Activities may include and not limited to canoeing, archery, rope course, arts and crafts, campfires, basketball, and dances.

**Medications:**

Campers will need to bring properly labeled medications to camp. The medications will be stored in the camp infirmary and distributed by members of the medical team throughout the day. Additional medication instructions will be provided at a later date.

**Cost:**

The cost to attend will be $160 per person.

**Who can apply?**

Children between 8-17 years of age at the time of camp diagnosed with a food allergy

**How to Apply:**

Fill out the application and submit it to foodallergynurse@texaschildrens.org. The camp committee will review all applications and choose the 28 campers to attend. ~~The deadline to apply is~~ **~~December 1, 2019.~~** ~~Campers will be notified no later than January 15, 2020.~~ The deadline to apply has been extended to January 10, 2020. Campers will be notified no later than February 1, 2020.

**How many applications will be accepted?**

At this is our first year to have Food Allergy Camp, we will only be accepting 28 applicants. We hope that the camp will continue to grow each year!

**Additional Forms:**

Applicants that are accepted to attend camp will be provided with additional forms to be filled out at a later date.

**Questions?**

Feel free to contact Daisy Tran, RN at dxtran1@texaschildrens.org with any questions that you may have.

**Food Allergy Camp Application**

**TO BE COMPLETED BY PARENT OR GUARDIAN**

**General Information**

|  |
| --- |
| Child’s Full Name: |
| Nickname (preferred name):  |
| Age at Camp:  | Date of Birth: | Gender: |
| Street Address: |
| City:  | State: | Zip Code: |
| Father/Guardian Name: | Father/Guardian Phone #: | Father/Guardian Cell #: |
| Father/Guardian E-mail: |
| Mother/Guardian Name: | Mother/Guardian Home #: | Mother/Guardian Cell #: |
| Mother/Guardian E-mail: |

**Friend or Relative to Contact in Case of an Emergency**

|  |
| --- |
| **Emergency contact #1** |
| Name: | Relationship: |
| Home #: | Cell #: |
| **Emergency contact #2** |
| Name: | Relationship: |
| Home #: | Cell #: |

**Health Insurance**

|  |  |
| --- | --- |
| Name of primary care physician: | Phone number: |
| Name of camper’s health insurance(s): |
| Name of Policy Holder (parent/guardian): | Insurance services phone#: |
| Member/Policy/ID#: | Group #:  |
| Medicaid #: |

**Health History**

|  |  |  |
| --- | --- | --- |
| **Please tell us if your child…** | **No** | **Yes** |
| Have any recent injury, illness or infectious disease? |  |  |
| Have a chronic or recurring illness/condition? |  |  |
| Have frequent headaches? |  |  |
| Ever had a head injury? |  |  |
| Ever been knocked unconscious? |  |  |
| Ever had frequent ear infections? |  |  |
| Ever passed out during or after exercise? |  |  |
| Ever been dizzy during exercise? |  |  |
| Ever had a seizure(s)? |  |  |
| Ever had high blood pressure? |  |  |
| Ever been diagnosed with a heart murmur? |  |  |
| Ever had a back problem? |  |  |
| Ever had problems with joints (e.g.: knees, ankles)? |  |  |
| Have any skin problems (e.g.: itching, rash, acne)? |  |  |
| Have diabetes? |  |  |
| Have asthma or bronchial asthma? |  |  |
| Ever had problems with diarrhea/constipation? |  |  |
| Have a history of bed-wetting? |  |  |
| Ever had an eating disorder? |  |  |
| Ever required professional help in order to cope with emotional difficulties? |  |  |
| Wear glasses, contacts or protective eyewear? |  |  |
| Have a history of aggressive behavior? |  |  |
| If female, have an abnormal menstrual history? |  |  |
| Allergic to any drugs? If yes, please describe: |  |  |
| History of nasal allergies? If yes, please describe: |  |  |
| History of eczema? If yes, please describe: |  |  |
| Stinging insect allergy? If yes, please describe: |  |  |

**Immunization Record**

|  |  |
| --- | --- |
| **Please indicate the date of the last immunization for:** | **Date** |
| Rubella TD (tetanus/diphtheria) |  |
| DTP Measles (hard or red or rubella) |  |
| Tetanus Hemophilus Influenza B |  |
| Polio Varicella Zoster |  |
| Hepatitis (A or B) |  |

|  |  |  |
| --- | --- | --- |
| Has the camper ever been diagnosed with any of the following: | No | Yes |
| Measles | ❑ | ❑  |
| Tuberculosis | ❑ | ❑  |
| Chicken Pox | ❑ | ❑  |
| German Measles | ❑  | ❑  |
| Mumps | ❑  | ❑  |
| Hepatitis A, B, C | ❑  | ❑  |

**Food Allergy History**

|  |
| --- |
| Please list all food allergies your child currently has: |
| Please describe past ingestion of allergen history (for each food): |
| Is your child involved in food immunotherapy/desensitization? If yes, please explain:Food:Route:Dosing Regimen:How long have they been on treatment?How are they tolerating it |
| Does your child have an unexpired epinephrine auto-injector? |
| Has your child ever required epinephrine during an allergic reaction? If yes, please explain. |

**Additional Information**

|  |
| --- |
| Does your child regularly take medication for:*Asthma:* ❑ Yes ❑ No*Allergic Rhinitis:* ❑ Yes ❑ No*Eczema:* ❑ Yes ❑ NoIf yes, please record in the medication form. |
| Does your child have feeding issues? Please describe. |
| Does your child have cultural/religious dietary requirements? |
| Any other dietary requirements? |
| Activities to be restricted or limited: |
| Please describe any special needs or concerns the staff should be aware of: |
| Is there any other information you think would be helpful for the camp staff to know? (ex: scared of the dark): |
| Does your child require assistance with activities of daily living (i.e. eating, bathing, toilet care, etc.)? |
| Has your child attended an overnight camp in the past? |
| Please have your child tell us why they would like to attend the Texas Children’s Hospital Food Allergy Camp: |

**Food Allergy Camp Medication Form**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drug Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Instructions**

1. Please complete the medication form
2. List all your child’s medications on the form. Include allergy medication/ointments/breathing treatments/vitamins etc.

If no medications, check the box ❑

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Drug Name | Dose **and** number of pills **or** amount of liquid | Route | Day and Time medicine is taken | Medicine description | Special instructions |
| EXAMPLE:*Cetirizine* | EXAMPLE:*5mg (one tablet)* | EXAMPLE:*Oral* | EXAMPLE:*Every day in the morning* | EXAMPLE:*Small white round dissolvable tablet* | EXAMPLE: |
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| --- | --- | --- | --- | --- | --- |
| Drug Name | Dose **and** number of pills **or** amount of liquid | Route | Day and Time medicine is taken | Medicine description | Special instructions |
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This health history is correct as far as I am aware. The child listed above has permission to engage in all activities except as noted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby give permission to the camp to provide ongoing health care. I also give permission to release my child’s medical information to the camp staff in order to fully care for my child.

Emergency Authorization: in the event that the parents/guardian and emergency contacts cannot be reached in an emergency, I hereby give permission to the physician and camp medical team to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the person named above. This form may be photocopied for use out of camp for medical purposes only.

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Printed Name of Parent/Legal Guardian Date

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Signature of Parent/Legal Guardian