



**October 15 – 16, 2011
Application**

Camper's Name _____ Date of Birth _____ Age _____ Gender _____

Address _____ Phone _____

(Street)

(City) (County) (State) (Zip)

Parent email _____ Child email _____

Name of School and Grade as of 2011/2012 _____

Please check how you learned of Chameleon's Journey:

Hospice & Palliative Care Charlotte Region _____ Other _____

Name of person who died _____ Age of Person _____

Cause of Death _____

Date of Death _____ Relationship to camper _____

Was child present at death? _____ Did child live with the person who died? _____

Please describe their relationship _____

Have there been other changes/stresses in your child's life (divorce, remarriage, relocation, illness, additional losses, etc)?

Is your child having any specific difficulty in school or in relationships with others? i.e.: inappropriate behavior, aggression, withdrawal _____

(over)

Has camper been in any grief support groups or sought counseling? If yes, please explain.

How do you know that your child is still grieving? (Describe behaviors, comments, expressions of grief)

Name and ages of household members

Please describe your child

**Camper's T- shirt size
(Circle One)**

Youth:

Small

Medium

Large

Adult:

Small

Medium

Large

X-large

2X

Desired name or nickname for camper name tag

I have received the Notice of Privacy Practices:

Yes

I have completed the Health History form:

Yes

I have completed the Consent/Liability Release form:

Yes

I have completed the Media Permission form:

Yes

(Enclose the Health History, Consent/Liability and Media forms with application)

Camper's Signature _____

**Parent/guardian
Signature** _____

Relationship to camper _____

Send to: Chameleon's Journey™
c/o Hospice & Palliative Care Charlotte Region
1420 East Seventh Street
Charlotte, North Carolina 28204
All information provided is confidential
Fax: 704.335.4304

Return Application no later than September 23, 2011

HEALTH HISTORY – 2011
CHAMELEON'S JOURNEY – Hospice & Palliative Care Charlotte Region
1420 EAST SEVENTH STREET CHARLOTTE, NC 28204
(704) 375-0100

A team of nurses will be on-site during Chameleon's Journey to attend to any medical needs. Please provide the following information regarding your child's Health History and Medications.

Camper _____ Parent/Guardian _____

Address _____ Phone _____

Cell Phone _____ Pager _____

If not available, in an emergency contact _____ Relationship _____

Address _____ Phone _____

Cell Phone _____ Pager _____

Health Conditions (check)

Diseases (approx. date)

Frequent ear infections _____

Chicken Pox _____

Heart Defect/Disease _____

Measles _____

Asthma _____

German Measles _____

Diabetes _____

Mumps _____

Epilepsy _____

Hepatitis _____

Physical Limitations _____

AIDS _____

Tetanus (date) _____

Other _____

Please explain any that are checked: _____

Operations or serious injuries (dates): _____

Allergies (list) Food: _____ Drug: _____ Other: _____

Behavioral problems: _____

Chronic/recurring illness (physical, emotional): _____

Any medically prescribed meal plan or dietary restrictions: _____

Are there any activities that should be restricted: _____

(continued...)

MEDICATION INFORMATION

- May the health care staff administer Tylenol? YES NO
- May the health care staff administer Ibuprofen? YES NO
- May the health care staff administer Pepto Bismol? YES NO
- May the health care staff administer Benadryl? YES NO

If not, please name alternative _____

- Does camper take any medications? YES NO
- If yes, please provide information below.

Medication name _____
Prescribed to treat (illness, disease) _____
Dosage/Frequency _____
How administered? (Orally, Injection, etc.) _____

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Prescribed to treat (illness, disease) _____
Dosage/Frequency _____
How administered? (Orally, Injection, etc.) _____

ALL PRESCRIPTION MEDICATIONS MUST BE BROUGHT TO CAMP IN THEIR ORIGINAL CONTAINER FROM THE PHARMACY, PROPERLY LABELED WITH CURRENT DOSAGE. A PHYSICIAN MUST VERIFY ANY CHANGES FROM THOSE ON THE CONTAINER IN WRITING. DUE TO THE CAMP'S STRUCTURED ACTIVITIES WE REQUIRE ANY SCHEDULED WEEK DAY BEHAVIORAL MEDICATION BE CONTINUED THROUGH THE WEEKEND. ALL MEDICATIONS MUST BE TURNED OVER TO THE HEALTH CARE STAFF AT THE REGISTRATION TABLE WHEN CHECKING IN ON SATURDAY. YOUR CHILD WILL NOT BE ABLE TO ATTEND THE CAMP IF SHE/HE DOES NOT HAVE APPROPRIATE PRESCRIPTION MEDICATIONS.

I hereby give my permission to the Chameleon's Journey medical staff to administer regular medications, or any needed over-the-counter medications and provide minor on-site care for my child.

Parent/Guardian _____ Date _____



THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USE AND DISCLOSURE OF HEALTH INFORMATION

Hospice & Palliative Care Charlotte Region, a North Carolina not for profit corporation d.b.a. Hospice at Charlotte, Hospice Lake Norman, Hospice of Lincoln County, Kids Path® and Palliative Care Consultants [the "organization"] may use your health information for purposes of providing you treatment, obtaining payment for your care and conducting health care operations. The organization has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

- To Provide Treatment. The organization may use your health information to coordinate care within the organization and with others involved in your care, such as your attending physician, members of the organization's interdisciplinary team and other health care professionals who have agreed to assist the organization in coordinating care. For example, physicians involved in your care will need information about your symptoms in order to prescribe appropriate medications. The organization also may disclose your health care information to individuals outside of the organization involved in your care including family members, clergy whom you have designated, pharmacists, suppliers of medical equipment or other health care professionals that the organization uses in order to coordinate your care.
- To Obtain Payment. The organization may include your health information in invoices to collect payment from third parties for the care you may receive from the organization. For example, the organization may be required by your health insurer to provide information regarding your health care status so that the insurer will reimburse you or the organization. The organization also may need to obtain prior approval from your insurer and may need to explain to the insurer your need for care and the services that will be provided to you.
- To Conduct Health Care Operations. The organization may use and disclose health care information for its own operations in order to facilitate the function of the organization and as necessary to provide quality care to all of the organization's patients. Health care operations includes such activities as:
 - Quality assessment and improvement activities.
 - Activities designed to improve health or reduce health care costs.
 - Contacting health care providers and patients with information about treatment alternatives and other related functions that do not include treatment.
 - Professional review and performance evaluation.
 - Training programs including those in which students, trainees or practitioners in health care learn under supervision.
 - Accreditation, certification, licensing or credentialing activities.
 - Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
 - Business planning and development including cost management and planning related analyses and formulary development.
 - Fundraising for the benefit of the organization and certain marketing activities.

For example the organization may use your health information to evaluate its staff performance, combine your health information with other organization's patients in evaluating how to more effectively serve all patients, disclose your health information to the organization's staff and contracted personnel for training purposes, use your health information to contact you as a reminder regarding a visit to you, or contact you or your family as part of general fundraising and community information mailings (unless you tell us you do not want to be contacted).

- The organization may disclose certain information about you including your name, general health status, your religious affiliation and where you are in the organization's facility in a Directory. The organization may disclose this information to people who ask for you by name. Please inform us if you do not want your information included in the directory.
- For Fundraising Activities. The organization may use information about you including your name, address, phone number and the dates you received care at the organization in order to contact you or your family to raise money for the organization. The organization may also release this information to a related organization foundation. If you do not want the organization to contact you or your family, notify *the Director of Development* and indicate that you do not wish to be contacted.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY ALSO BE USED AND DISCLOSED:

- When Legally Required. The organization will disclose your health information when it is required to do so by any Federal, State or local law.
- When There Are Risks to Public Health. The organization may disclose your health information for public activities and purposes in order to:
 - Prevent or control disease, injury or disability, report disease, injury, vital events such as birth or death and the conduct of public health surveillance, investigations and interventions.
 - To report adverse events, product defects, to track products or enable product recalls, repairs and replacements and to conduct post-marketing surveillance and compliance with requirements of the Food and Drug Administration.
 - To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.
 - To an employer about an individual who is a member of the workforce as legally required.
- To Report Abuse, Neglect Or Domestic Violence. The organization is allowed to notify government authorities if the organization believes a patient is the victim of abuse, neglect or domestic violence. The organization will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.
- To Conduct Health Oversight Activities. The organization may disclose your health information to a health oversight agency for activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The organization, however, may not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.
- In Connection With Judicial And Administrative Proceedings. The organization may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process,.
- For Law Enforcement Purposes. The organization may disclose your health information to a law enforcement official for law enforcement purposes as follows:
 - As required by law for reporting of certain types of wounds or other physical injuries pursuant to the court order, warrant, subpoena or summons or similar process.
 - For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
 - Under certain limited circumstances, when you are the victim of a crime.
 - To a law enforcement official if the organization has a suspicion that your death was the result of criminal conduct including criminal conduct at the organization.
 - In an emergency in order to report a crime.
- To Coroners And Medical Examiners. The organization may disclose your health information to coroners and medical examiners for purposes of determining your cause of death or for other duties, as authorized by law.
- To Funeral Directors. The organization may disclose your health information to funeral directors consistent with applicable law and if necessary, to carry out their duties with respect to your funeral arrangements. If necessary to carry out their duties, the organization may disclose your health information prior to and in reasonable anticipation, of your death.
- For Organ, Eye Or Tissue Donation. The organization may use or disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue for the purpose of facilitating the donation and transplantation.
- For Research Purposes. The organization may, under very select circumstances, use your health information for research. Before the organization discloses any of your health information for such research purposes, the project will be subject to an extensive approval process. The organization will ask your permission if any researcher will be granted access to your individually identifiable health information.
- In the Event of A Serious Threat To Health Or Safety. The organization may, consistent with applicable law and ethical standards of conduct, disclose your health information if the organization, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.
- For Specified Government Functions. In certain circumstances, the Federal regulations authorize the organization to use or disclose your health information to facilitate specified government functions relating to military and veterans, national security and intelligence activities, protective services for the President and others, medical suitability determinations and inmates and law enforcement custody.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than is stated above, the organization will not disclose your health information without your written authorization. If you or your representative authorizes the organization to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the organization maintains:

- Right to request restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the organization's disclosure of your health information to someone who is involved in your care or the payment of your care. However, the organization is not required to agree to your request. If you wish to make a request for restrictions, please contact the Privacy Official at 704-375-0100.
- Right to receive confidential communications. You have the right to request that the organization communicate with you in a certain way. For example, you may ask that the organization only conduct communications pertaining to your health information with you privately with no other family members present. If you wish to receive confidential communications, please contact the Privacy Official at 704.375.0100.
- Right to inspect and copy your health information. You have the right to inspect and copy your health information, including billing records. A request to inspect and copy records containing your health information may be made to the Privacy Official at 704.375-0100. If you request a copy of your health information, the organization may charge a reasonable fee for copying and assembling costs associated with your request.
- Right to amend health care information. If you or your representative believes that your health information records are incorrect or incomplete, you may request that the organization amend the records. That request may be made as long as the information is maintained by the organization. A request for an amendment of records must be made in writing to the Privacy Official at 704.375.0100. The organization may deny the request if it is not in writing or does not include a reason for the amendment. The request also may be denied if your health information records were not created by the organization, if the records you are requesting are not part of the organization's records, if the health information you wish to amend is not part of the health information you or your representative are permitted to inspect and copy, or if, in the opinion of the organization, the records containing your health information are accurate and complete.
- Right to an accounting. You or your representative have the right to request an accounting of disclosures of your health information made by the organization for any reason other than for treatment, payment or health operations. The request for an accounting must be made in writing to the Privacy Official. The request should specify the time period for the accounting starting on April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. The organization would provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.
- Right to a paper copy of this notice. You or your representative has a right to a separate paper copy of this Notice at any time even if you or your representative have received this Notice previously. To obtain a separate paper copy, please contact the Privacy Official at 704-375-0100. The organization's patient or a representative may also obtain a copy of the current version of the organization's Notice of privacy practices at its website, www.Hospiceatcharlotte.com

DUTIES OF THE ORGANIZATION

The organization is required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of its duties and privacy practices. The organization is required to abide by terms of this Notice as may be amended from time to time. The organization reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all health information that it maintains. If the organization changes its Notice, the organization will provide a copy of the revised Notice to you or your appointed representative. You or your personal representative have the right to express complaints to the organization and to the Secretary of Health and Human Services if you or your representative believe that your privacy rights have been violated. Any complaints to the organization should be made in writing to the Privacy Official. The organization encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

The organization 's contact person for all issues regarding patient privacy and your rights under the Federal privacy standards is the Privacy Official, 1420 East Seventh Street, Charlotte, NC 28204; 704.375.0100.



MEDIA PERMISSION FORM

To communicate Chameleon's Journey mission and message we may want to use photos, videotapes, websites, quotations, stories, artwork, and other artistic expressions of the children, and parent-guardians for display boards, brochures, newsletters, lectures, or trainings. The last name and detailed information about the child, teen, or parent-guardian will not be spoken or printed.

_____ We give permission to the above uses of pictures, photos, artwork, quotations, stories, and videotapes.

_____ We give our permission with the following exceptions:

_____ We do NOT give our permission to any of the above.

Signature

Date



Parent/Guardian Consent and Liability Release Form

The undersigned does hereby give permission for our (my) child, _____ to attend and participate fully in the activities of Chameleon's Journey. We (I) _____, authorize an adult, in whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

The undersigned also gives permission for their child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities sponsored by Chameleon's Journey.

Camp Participant _____

Hospital Insurance YES NO

Insurance Company _____

Policy Number _____ Group# _____ Effective Date _____

Physician Name _____ Phone Number _____

Parent/Guardian _____

Emergency Phone Numbers _____

(continued....)

In consideration for being accepted by Chameleon's Journey for participation in the camp activities, we (I), being 21 years of age or older, do for ourselves (myself) (and for and on behalf of my child-participant) hereby release, forever discharge and agree to hold harmless Chameleon's Journey, Hospice at Charlotte, Hospice of Lincoln County, and the directors thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the child-participant that occur while said child is participating in the above-described camp.

Furthermore we (I) _____ and on behalf of our (my) child-participant hereby assume all risk of personal injury, sickness, death, damage and expenses as a result of participation in recreation and activities involved therein.

Further, authorization and permission is hereby given to said camp to furnish any necessary transportation, food and lodging for this participant.

The undersigned further hereby agrees to hold harmless and indemnify said camp, its directors, employees and agents, for any liability sustained by said camp as the result of the neglect, willful or intentional acts of said participant, including expenses incurred attendant thereto.

The undersigned further acknowledges that we (I) have received a copy of the organization's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which our (my) child's health information may be used or disclosed by the organization and of our (my) rights with respect to our (my) child's health information.

Further should it be necessary for the participant to return home due to medical reasons, disciplinary action or otherwise, we (I) will arrange for transportation home.

Parent/Guardian signature _____ **Date** _____