

(For Office Use Only) Date Received _____

Participant Application

The participant application must be received along with a completed physical exam form (the second half of this application) before a family will be considered to attend one of our 2007 summer sessions of the retreat. Please type or print clearly all information on this form.

General Information

Child's Full Name: _____

Parent/Guardian's Full Name(s): _____

Address: _____ Phone: (____) _____

City: _____ State: _____ Zip: _____ E-mail: _____

Child's Age: _____ Date of Birth: _____ Social Security Number: _____ Male Female

Nickname or name child prefers to be called: _____

Does the child have any school age siblings we can invite to the retreat? Yes No

If so, what are the name(s) and age(s): _____

How did you hear about Janua Coeli? Internet Another Participant Other _____

Medical Personnel Name _____ Position _____ Hospital _____

Have you been to Janua Coeli before? Yes No If Yes, please give us some dates and details : _____

Have you been to another charity retreat before? Yes No If Yes, please give us some dates and details : _____

This form, plus a completed Physical Exam Form must be received by Janua Coeli before participant will be considered to attend.

Emergency Contact

Name(s): _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ Cell: (____) _____ Work: (____) _____

Janua Coeli Cancer Foundation

Foundation Office: 300 Janua Coeli Way, Rutherfordton, NC 28139 Office Phone: (828) 287-8886 Office Fax: (828) 287-8995
Email: januacoeli@bellsouth.net Web site: www.januacoelicancerfoundation.com

Physician Information

Oncologist: _____ Primary Care Provider: _____
Institution: _____ Institution: _____
Address: _____ Address: _____
Phone: (_____) _____ Phone: (_____) _____
Emergency Number: _____ Emergency Number: _____

Medical Information

Does child have PortaCath? Yes No Type: _____
Does child have a Central Line? Yes No If yes, external or internal? _____
If external line: Flushed how often? _____ With what amount and strength of Herapin? _____
Dressing changed how often? _____ Needs help with Catheter Care? Yes No (Please bring all supplies with you)
May child shower? Yes No May child swim in Chlorine-treated pool? Yes No
May child swim in a stream? Yes No (Any dressing will be changed immediately after swimming)

Medications

Bring all medications, chemotherapy, catheter dressings and any other supplies necessary for you. Any assistance in storage or administration of medication is available upon request. Medications should be brought to camp in original pharmacy bottles. (Continue list on additional page if needed.)

Oral Medications

Drug Name and Strength	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Special Needs

Is child allergic to any food or drugs? Yes No If Yes, please explain: _____

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Is child currently being treated for any other medical condition such as Asthma, ADD, Diabetes, Seizure disorders, etc.?

Yes No If **Yes**, please explain: _____

Do you have any special equipment, such as a walker, crutches, wheelchair or prosthesis? _____

Dietary restrictions and/or special food needs? Yes No If **Yes**, please explain: _____

Is child's immunizations up to date? Yes No If **No**, please explain: _____

Has the child had chicken pox? Yes No If **Yes**, when? _____

PLEASE NOTE: Alert us if you have been exposed to any communicable disease (chicken pox, measles or mumps) 1 to 3 weeks before camp.

Does child function at age level? Yes No If **No**, explain _____

Unusual bedtime or sleep habits (sleepwalking, nightmares, bedwetting, snoring)? _____

Does child have permission to swim? Yes No

Does child know how to swim? Yes No

Does child need full time help in water? Yes No

Any special needs in water? Yes No

List any other special needs: _____

Do you have a travel preference? Yes No If so, please specify: Fly Drive Other : _____

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Insurance

Please enclose photocopy of both sides of this card

Account in name of: _____

Name of Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Policy Number: _____

Group Number: _____ ID Number: _____

If Medicaid, indicate Number: _____

Billing instructions: _____

Prescription Plan Information

Please enclose photocopy of both sides of this card

Plan in name of: _____

Name of Prescription Plan Provider: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Policy Number: _____

Group Number: _____ ID Number: _____

Consent Agreement, Authorization And Release

This Consent agreement, Authorization and Release must be read and signed for the participant to be eligible to attend Janua Coeli.
This form must be completed and signed by parent/guardian.

Child's Full Name (print): _____

RELEASE OF LIABILITY

The undersigned understands that occasionally accidents occur during retreat activities and that participants may sustain serious personal injury and property damages as a consequence thereof. Knowing the risks of retreat activities, nevertheless, and in consideration of acceptance for participation at the retreat, the undersigned hereby agrees to assume those risks and to hold harmless the Janua Coeli Cancer Foundation, and all retreat agents, representatives, employees, and volunteers from any and all liability, claims for personal injury and/or property damage, costs, expenses and damages arising out of or connected in any way with participation in retreat activities. Further, the undersigned acknowledges that Janua Coeli accepts no responsibility for the loss, damage or theft of personal property.

CONSENT FOR MEDICAL TREATMENT

The undersigned hereby grants permission to the medical staff or consulting physicians at Janua Coeli to administer medication and provide medical care, including any medical emergency care required. I also give consent for any emergency transportation deemed necessary.

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PHOTO AND INFORMATION RELEASE

I give Janua Coeli permission to photograph and use pictures or visual and audio tapes of above named participant in professional or fund-raising activities. The philosophy of Janua Coeli is to photograph participants infrequently. On occasion, with this permission, participants' photographs may be included in a bulletin board, video, newsletter, retreat album, or in personal photographs. The foundation respects the privacy of its participants and does not allow unauthorized visitors to photograph the retreat or children. In addition, by signing below, I give Janua Coeli permission to give the child's name, address, and/or phone number to groups or individuals wishing to support Janua Coeli by inviting to an event or sending information related to the retreat. This list will not be sold or given to anyone else for any other reason.

PARTICIPATION CONSENT

The undersigned gives permission for the child to participate in any and all activities, including transportation to and from the retreat for retreat activities, except those specifically prohibited by child's physician or guardian/parent listed below.

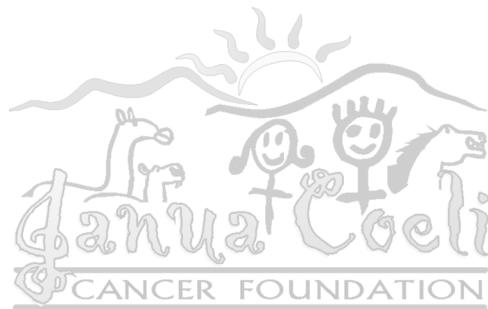
X _____ Date: _____

Parental/guardian signature is required above. Parent/guardian must also note all activities prohibited for this participant: _____

Please return completed form by mail to:

Janua Coeli Cancer Foundation
Attn: Applications
300 Janua Coeli Way
Rutherfordton, NC 28139

Or Fax all pages of the form with a cover letter addressed to "Applications" to (828) 287-8995.



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