BLEEDING DISORDERS FOUNDATION OF NORTH CAROLINA

Teen Retreat
August 10-13, 2023
Rock Hill, SC

BLEEDING DISORDERS ASSOCIATION OF SOUTH CAROLINA

Registration – *Complete one form for EACH teen participant*

☞ ***PLEASE PRINT***:

Name: _____ Nickname: _____

Address: _____

City, State, Zip: _____ Home phone: _____

Email: _____ Cell phone: _____

Gender: _____ Age:_____ Date of Birth:_____

T-shirt Size (adult sizes):_____

Do you have a bleeding disorder? ❑ Yes ❑ No If yes, do you self-infuse? ❑ Yes ❑ No

Primary Doctor:_____ Phone: _____

HTC/Hematologist:_____ Phone: _____

Parent/Guardian Name:_____

Phone(s) — home:_____ work:_____ cell:_____

Address (if different from above): _____

City, State, Zip: _____

Emergency Contact Name: _____

Emergency Contact Phone – home:_____ cell: _____

Allergies and other pertinent health history: _____

_____

Insurance Information:

Insurance Company Name/Medicaid/Medicare: _____

Policy #:_____ Group #:_____ Phone: _____

Name of friend attending with you: _____

(Your friend will also need to complete a registration and permission form.)

Revised May 25, 2023

BLEEDING DISORDERS FOUNDATION OF NORTH CAROLINA

Teen Retreat
August 10-13, 2023
Rock Hill, SC

BLEEDING DISORDERS ASSOCIATION OF SOUTH CAROLINA

Complete one form for EACH teen participant

Parent/Guardian Permission and Release Statement:

I hereby give permission for my child, _____, to participate in the Bleeding Disorders Foundation of North Carolina (BDFNC) and Bleeding Disorders Association of South Carolina (BDASC) Summer 2023 Teen Retreat activities. In consideration of the benefits derived, I expressly waive all claims against BFDNC, BDASC, the National Hemophilia Foundation, and the officers, trustees, employees, physicians, agents, volunteers and/or representatives of the aforementioned and others associated with the retreat, on account of any accident, injury and/or illness that may occur to my child during the retreat, and hereby indemnify, hold harmless and release them from any and all liability which might arise from the above named person's participation in this retreat.

I grant permission for my child to receive treatments for hemophilia, von Willebrand disease, or any other medical problems while at the weekend. In the event of a medical emergency, I grant permission for my child to be transferred to and treated at a medical facility. I will be responsible for all costs incurred for emergency or inpatient care.

I understand that my child will be participating in physical activity during the retreat and it is recommended that I consult with their physician or other medical staff regarding any limitations or restrictions. I further understand that it is my responsibility to communicate any such limitations or restrictions to BDFNC or BDASC.

I grant permission to take pictures of my child and use in publicity materials/newsletters.

Parent/Guardian Signature: _____ Date:_____

Teen Participant Behavior Expectation Contract:

By attending the BDFNC/BDASC Retreat, I, _____ agree to:

- Show respect to other Retreat participants, facilitators and guests, and most importantly, to myself. This includes following the instructions of the facilitators, participating in activities presented, and refraining from put-downs or other hurtful behavior directed towards others.
- Abstain from using or bringing illegal drugs, alcohol or weapons (including pocket knives) to this event.
- Refrain from inappropriate language and gestures.
- Follow all rules and guidelines.

If I fail to follow these guidelines, I understand that I will be asked to leave the Retreat and that I may not be invited to future programs sponsored by either BDFNC or BDASC.

Participant Signature: _____ Date:_____

Parent/Guardian Signature: _____ Date:_____

Revised May 25, 2023

BLEEDING DISORDERS FOUNDATION OF NORTH CAROLINA

Teen Retreat
August 10-13, 2023
Rock Hill, SC

BLEEDING DISORDERS ASSOCIATION OF SOUTH CAROLINA

The registration deadline is Monday, July 10, 2023.
Spaces are limited; first come, first served.

For each applicant, be sure to include a completed and signed the Camp Canaan activity release form, the Leading Edge (GutMonkey) participant agreement from, and the sponsor's (Pfizer) photo/audio/video release form.

Additional registration, permission and waiver forms are available online at:

bleedingdisordersnc.org
and
www.bda-sc.org

Please return completed forms by mail or fax to:

☞ ***North Carolina Residents***

Mail: **Charlene Cowell**
Bleeding Disorders Foundation of North Carolina
260 Town Hall Drive, Suite A
Morrisville, NC 27560
Fax: **(919) 319-0016**
Phone: **(919) 319-0014**
Email: **info@bleedingdisordersnc.org**

☞ ***South Carolina Residents***

Mail: **Sue Martin**
Bleeding Disorders Association of South Carolina
25 Woods Lake Road, Suite 300
Greenville, SC 29607
Fax: **(864) 236-8663**
Phone: **(864) 350-9941**
Email: **sue.martin@bda-sc.org**

If you have reserved a space, but later learn that you will be unable to attend, please let us know. It's important that we provide an accurate advance count to our food vendors, who must charge us on a per-person basis. It will also help us better accommodate last-minute applicants for whom we might otherwise not have enough space reserved.

Thank you!

As non-profit advocates for the bleeding disorders community, the Bleeding Disorders Foundation of North Carolina and the Bleeding Disorders Association of South Carolina (BDFNC/BDASC) have no affiliation with the pharmaceutical, home care, or specialty pharmacy industries or any other for-profit corporation. Corporate logos and/or links to corporate websites may appear on BDFNC/BDASC posters, flyers and websites to recognize sponsorship of specific events or projects. BDFNC and BDASC never endorse treatment products, manufacturers, home care services or individual medical providers.

Please know that your personal information will be treated as completely confidential. Neither BDFNC nor the BDASC will ever share, give or sell your name, address or health-related information to any other organization, company or individual without your express permission.

Revised May 25, 2023

Medication List – BDFNC/BDASC Teen Retreat

Teen Name: _____ **DOB:** _____

Parent/Guardian Instructions

List all medications on the form(s) below, including non-prescription drugs such as Tylenol, that your child is bringing to the Retreat. Use additional forms if needed. Be sure to put your child's name and date of birth (DOB) at the top of each page.

For injectable medications, such as factor replacement products, please send an appropriate number of needles, syringes, and any other special ancillary supplies your child may need. The Retreat facility will be equipped with a suitable area for administration, along with basic bandaging, alcohol wipes, gauze pads, Band Aids, and sharps disposal containers.

All medications must be brought in their original containers, or as dispensed by the pharmacy with pharmacy label attached. With your permission, your child may be allowed to keep certain medications in their possession (see below). All other medications, including those that require refrigeration, will be kept in a secure facility.

An experienced registered nurse will be present during the entire time of the Retreat, and will be available at all hours to dispense medications and assist with their administration.

In the **Dosing and Administration** section for each medication, please list the instructions as printed on the pharmacy label (for prescription drugs) or product container (for non-prescription drugs). In the case of "use as directed" or "as needed" medications, please include the apropriate dose amount, frequency, administration method (such as IV or subcutaneous for injectables), and any other necessary instructions.

In the **Storage requirements and other special instructions** section, please indicate if the medication requires refrigeration or other special handling. Also indicate if the drug is intended for emergency use only.

Self medicating and self-administration: Please indicate and initial If your child is capable of self-administering the medication(s) as directed, and has your permission to do so.

Transfer of possession: All medications, administration supplies, and the completed forms (below) must be presented to Retreat staff at transportation check-in (or at arrival at the Retreat facility if providing own transportation). If your child has your permission to keep this medication in their posession, please indicate this and initial the form. Your signature below acknowledges that the Retreat staff have final say over whether your child may keep the medication in their possession; and if so, that you and your child assume responsibility for its safekeeping and proper use. *Under no circumstances may your child share any medication with other Retreat participants.*

Parent/Guardian Consent

I give permission for my child to receive the medication(s) described below, as directed, during the BDFNC/BDASC Teen Retreat.

_____ _____ _____

(signature) *(print name)* *(date)*

Medication List – BDFNC/BDASC Teen Retreat

Teen Name: ____ **DOB:** ____________

Medication Name: ____

Dosing and Administration (from product or pharmacy label): ____

____

Purpose/Prescribed for: ____

____

Side effects/adverse reactions staff should watch for: ____

____

Storage requirements and other special instructions: ____

____

❑ My child has permission to self-administer this medication. *Parent/guardian initials:* ___________

❑ My child has permission to retain possession of this medication while attending Retreat. *Parent/guardian initials:* ___________

Staff use only: ❑ Emergency use only ❑ Refrigerate ❑ With participant ❑ Controlled

Medication Name: ____

Dosing and Administration (from product or pharmacy label): ____

____

Purpose/Prescribed for: ____

____

Side effects/adverse reactions staff should watch for: ____

____

Storage requirements and other special instructions: ____

____

❑ My child has permission to self-administer this medication. *Parent/guardian initials:* ___________

❑ My child has permission to retain possession of this medication while attending Retreat. *Parent/guardian initials:* ___________

Staff use only: ❑ Emergency use only ❑ Refrigerate ❑ With participant ❑ Controlled

Medication Name: ____

Dosing and Administration (from product or pharmacy label): ____

____

Purpose/Prescribed for: ____

____

Side effects/adverse reactions staff should watch for: ____

____

Storage requirements and other special instructions: ____

____

❑ My child has permission to self-administer this medication. *Parent/guardian initials:* ___________

❑ My child has permission to retain possession of this medication while attending Retreat. *Parent/guardian initials:* ___________

Staff use only: ❑ Emergency use only ❑ Refrigerate ❑ With participant ❑ Controlled