Dear Parents,

NATIVE HEALTH is pleased to announce the Indigenous Wellness Camp, **Monday, July 22–Friday, July 26, 2024** at Emmanuel Pines Camp and Retreat Center in Yavapai County, Arizona, for American Indian/Alaska Native children, ages 9-13 years old.

Applications are only accepted when all forms are completed. Please read the entire packet with your child so everyone has a successful and enjoyable time. If you live in Maricopa County, physicals must be completed by a NATIVE HEALTH medical provider, at any of our locations. COVID-19 vaccination is required. **Deadline for applications is Wednesday, July 17, 2024**.

NATIVE HEALTH is entering its 22nd year offering American Indian/Alaska youth tools to reduce the risk of developing Type 2 Diabetes. In addition to offering a fun outdoor camping experience, the Indigenous Wellness Camp also provides education on the importance of nutrition, physical activity, self-esteem, diabetes prevention, and traditional activities.

Behavior and discipline problems can affect camp activities and other children's camping experience. Parents will be contacted in the event behavior problems arise, and campers may be dismissed and will have to be picked up by the parent/guardian at the camp, at your own cost.

Please do not mail or send any food, drinks or candy for your camper. We do not allow food in the living units because these items attract rodents or wildlife. Three meals as well as morning and afternoon snacks will be provided.

The Indigenous Wellness Camp is a place for safe, wholesome fun and learning. We are dedicated to keeping it that way. Thank you for sharing your camper with us and we will be working very hard to make sure they have a great time at camp this summer.

If you have any questions please call **(602) 279-5262 ext. 13007**, Monday through Friday, 8 a.m.–5 p.m., or email: **gbegay@nachci.com**.

Thank you,

Gabrielle Begay
NATIVE HEALTH Indigenous Wellness Coordinator

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INDIGENOUS WELLNESS CAMP

Camp Rules

1. Profanity will NOT be tolerated.
2. Drugs, alcohol, cigarettes, fireworks, firearms, knives or weapons of any kind are prohibited.
3. Suggestive, bullying or aggressive behavior or malicious pranks will NOT be tolerated.
4. Please do not bring any electronic devices (cell phone/iPad/Kindle, etc.). We are NOT responsible for theft.
5. NO food or drinks allowed on trip or in cabins.
6. Be on time to activity classes, meals and evening events.
7. Practice the buddy system at all times.
8. Keep camp grounds clean of litter.
9. Graffiti will NOT be tolerated in cabin walls, etc. The offender will be responsible for cleanup and repair.
10. Camper's parents are not allowed to be a chaperon.

Cabin/Housing

- Campers stay with other campers of the same gender and similar age
- Campers and counselors sleep in cabins
- Two Team Leaders are assigned per group with youth of same gender

Camp Activities

- Arts and Crafts
- Native American Cultural Activities
- Native Games
- Talking Circles
- Team Building Activities
- Traditional Food Demos

Home Sickness

Know that your child will get homesick. Team Leaders are trained to recognize homesickness and know how to cheer up campers and get them back on the right track. If homesickness becomes extreme such as not eating or crying all the time, you will be contacted to reassure them or pick them up. You may pack comforting items such as a stuffed animal, family picture, etc.

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PLEASE BRING ENTIRE FORM WITH YOU TO MEDICAL APPOINTMENT

PLEASE PRINT CLEARLY

Child's Name_____ Date of Birth_____ Age_____ ☐ Male ☐ Female

Name of Parent/Guardian_____

Address of Parent/Guardian_____

Cell phone:_____ Email_____

Emergency Contact Name_____ Relationship:_____

Emergency Contact Phone_____ Emergency Contact Email_____

Tribal Affiliation (Tribal ID/CIB not required)_____

Personal Physician's Name_____ Phone_____

Hospital Preference_____

Name of Medical Insurance_____ Name of Policy Holder_____

Group #_____ Type of Insurance _____

Policy Holder Date of Birth_____ Insurance Phone #_____

By signing this form, my child and I agree that he/she will abide by the citizenship standards of the events, including maintaining a cooperative attitude. We also agree that absolutely NO tobacco, liquor, weapons or illegal drugs may be brought, used or possessed during the session. The Activity Director has the sole discretion of dismissing any child for behavior detrimental to other participants. I understand that, should my child be dismissed for disciplinary reasons that cannot be resolved, Parent or Sponsor will be notified and expected to pick up his/her child immediately. Parents or Guardians will be held financially responsible for all damages caused by said child.

1. I hereby give my permission to NATIVE HEALTH the right to use, publish, or share images of me or my child in any media (e.g., photographs, digital images, video, audio, Internet, internal materials, or other promotional materials) to be used solely for the purposes of carrying out the NATIVE HEALTH mission. I understand that using the image will be the property of NATIVE HEALTH. I also give permission for NATIVE HEALTH to share these images with other organizations, affiliations, or partnerships such as Indian Health Service, HRSA, CDC, etc. I am providing these services to NATIVE HEALTH without financial compensation and will not make any claims against NATIVE HEALTH for compensation of these services.
2. I understand that acceptance is not automatic. A physical examination by a NATIVE HEALTH medical provider and all completed forms are required prior to camp participation. Signed forms must be received by Wednesday, July 17th, 2024.
3. In the event my child is injured, I hereby authorize the camp registered nurse to act on my behalf in arranging for medical care (unless otherwise specified) at my expense in any case regarding this child which in their opinion requires diagnosis and/or treatment. Emergency contacts will be notified of any injuries/illnesses.
4. In the event that my child may be showing signs of COVID infection, i.e. fever and/or cough, I authorize the assigned registered nurse to test my child for COVID infection. If the result is positive I understand that my child will be dismissed to return home and that the Parent or Sponsor will be notified and expected to pick up his/her child immediately.
5. I release the NATIVE HEALTH, its directors, staff, volunteers and contracted personnel - Emmanuel Pines Camp and Retreat Center, its officers, directors and other personnel and volunteers, from all liability for any injury which may result from any activity, equipment and/or first aid treatment

With my Signature, I certify that I have read and understand the information provided on the form, and that I accept the terms and conditions. I waive all rights and claims for damages against NATIVE HEALTH which may result during the Indigenous Wellness Camp.

Print Name of Parent/Guardian	Parent/Guardian Signature	Date
Print Name of Child	Child Signature	Date

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Child's Name_____ Date of Birth_____

Does your child have any allergies to? ☐ Animals or Insects ☐ Foods ☐ Medications ☐ Outdoors

If yes, please list reactions and how severe:_____

Does your child require any special diet or restriction of certain foods? ☐ Yes ☐ No If yes, please list:_____

Medication (over the counter and prescription)

What medications does your child take daily or on an "as needed" basis? (please include inhalers for asthma, eye drops, nasal spray, allergy pills, prescription medications). All medications must be placed in a clear, re-sealable zipper storage bag with all medications marked individually with their name and dosage information:

Medication_____
Type_____
Dosage_____
When and How Often?_____

Medication_____
Type_____
Dosage_____
When and How Often?_____

Medication_____
Type_____
Dosage_____
When and How Often?_____

Medication_____
Type_____
Dosage_____
When and How Often?_____

Behavioral Health issues

Has your child been away from home for more than one night? ☐ Yes ☐ No

Does the child have any physical restrictions? ☐ Yes ☐ No If yes, please explain:_____

Does the child have any history of sexually acting out behaviors? ☐ Yes ☐ No If yes, please explain:_____

Does your child have significant phobia, fears, sensory stimulation, or anxiety concerns? (e.g. dark, too much quiet, too loud, etc.) ☐ Yes ☐ No
If yes, please list:_____

Does the child have any history of having been bullied by others? ☐ Yes ☐ No

Has your child diagnosed with a mental health condition or have behavioral issues (aggressiveness, defiant to authority, hyperactivity, poor peer interaction)? ☐ Yes ☐ No If yes, please explain:_____

Physical Activity

How many hours a day does your child do the following:_____Watch TV_____Play Video Games_____Computer

Does your child like physical activity, outdoor play, or playing sports? ☐ Yes ☐ No

What are the things that get in the way of doing more outdoor activities or active play for your child and your family? (barriers to physical activity)

How many hours of sleep per night does your child usually get?_____

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Child's Name_____ Date of Birth_____

Exam Date:_____

Please circle questions you don't know the answers to.

Has a doctor ever denied or restricted your child's participation in sports for any reason? ☐ Yes ☐ No

Does your child have an ongoing medical condition (like diabetes or asthma)? ☐ Yes ☐ No

Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? ☐ Yes ☐ No
(Please specify):_____

Do you have allergies to medicines, pollens, foods, or stinging insects? ☐ Yes ☐ No
(Please specify):_____

Does your child's heart race or skip beats during exercise? ☐ Yes ☐ No

Has a doctor ever told you that your child has (check all that apply):

☐ high blood pressure ☐ a heart murmur
☐ high cholesterol ☐ a heart infection

Has your child ever spent the night in the hospital? ☐ Yes ☐ No

Has your child ever had surgery? ☐ Yes ☐ No

Has your child ever had an injury? (sprain, muscle/ligament tear, tendinitis, etc.) (If yes, check affected area in the box below): ☐ Yes ☐ No

Has your child had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below): ☐ Yes ☐ No

Have you had a bone/joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? (If yes, check affected area in the box below): ☐ Yes ☐ No

☐ Head	☐ Elbow	☐ Upper Back	☐ Knee
☐ Neck	☐ Forearm	☐ Low Back	☐ Calf/Shin
☐ Shoulder	☐ Hand/Fingers	☐ Hip	☐ Ankle
☐ Upper Arm	☐ Chest	☐ Thigh	☐ Foot/Toes

Has your child ever had a stress fracture? ☐ Yes ☐ No

Have you been told that your child has or had an x-ray for atlantoaxial (neck) instability? ☐ Yes ☐ No

Does your child regularly use a brace or assistive device? ☐ Yes ☐ No

Has a doctor told you that your child has asthma or allergies? ☐ Yes ☐ No

Does your child cough, wheeze, or have difficulty breathing during or after exercise? ☐ Yes ☐ No

Is there anyone in your family who has asthma? ☐ Yes ☐ No

Has your child ever used an inhaler or taken asthma medicine? ☐ Yes ☐ No

Was your child born without, is missing, or has a nonfunctioning kidney, eye, testicle or any other organ? ☐ Yes ☐ No

Has your child had infectious mononucleosis (mono) within the last month? ☐ Yes ☐ No

Do your child have any rashes, pressure sores, or other skin problems? ☐ Yes ☐ No

Has your child had a herpes skin infection? ☐ Yes ☐ No

Has you ever had an injury to their face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to the head, having "bell rung" or getting "dinged")? ☐ Yes ☐ No

Has your child ever had a seizure? ☐ Yes ☐ No

Does your child have headaches with exercise?

Has your child ever had numbness, tingling, or weakness in your arms or legs after being hit, falling, stingers or burners? ☐ Yes ☐ No

When exercising in the heat, does your child have severe muscle cramps or become ill? ☐ Yes ☐ No

Has a doctor told you that your child or someone in your family has sickle cell trait or sickle cell disease? ☐ Yes ☐ No

Has your child ever been tested for sickle cell trait? ☐ Yes ☐ No

Has your child had any problems with their eyes or vision? ☐ Yes ☐ No

Does your child wear glasses or contact lenses? ☐ Yes ☐ No

Does your child wear protective eyewear, such as goggles or a face shield? ☐ Yes ☐ No

Is your child happy with their weight? ☐ Yes ☐ No

Is your child trying to gain or lose weight? ☐ Yes ☐ No

Has anyone recommended your child change their weight or eating habits? ☐ Yes ☐ No

Do you limit or carefully control what your child eats? ☐ Yes ☐ No

Do you have any concerns that you would like to discuss with a NATIVE HEALTH/NHW provider ☐ Yes ☐ No

Has your child ever had a menstrual period? ☐ Yes ☐ No

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Child's Name_____ Date of Birth_____

NATIVE HEALTH provider should fill out this form with assistance from the parent or guardian.

Patient History Questions: Please tell me about any of the following in your family:

Has your child fainted or passed out DURING or AFTER exercise, emotion or startle? ☐ Yes ☐ No

Has your child had extreme fatigue associated with exercise (different from other children)? ☐ Yes ☐ No

Has your child ever had extreme shortness of breath during exercise? ☐ Yes ☐ No

Has your child ever had discomfort, pain or pressure exercise? in his/her chest during ☐ Yes ☐ No

Has a doctor ever ordered a test for your child's heart? ☐ Yes ☐ No

Has your child ever been diagnosed with an unexplained seizure disorder? ☐ Yes ☐ No

Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication? ☐ Yes ☐ No

Are there any family members who had sudden, unexpected, unexplained death before age 50? (including SIDS, car accidents, drowning, or near drowning) ☐ Yes ☐ No

Are there any family members who died suddenly of "heart problems" before age 50? ☐ Yes ☐ No

Are there any family members who have unexplained fainting or seizures? ☐ Yes ☐ No

Are there any relatives with certain conditions, such as:

☐ Deaf at Birth (congenital deafness)

Enlarged Heart

☐ Hypertrophic Cardiomyopathy (HCM) ☐ Dilated Cardiomyopathy (DCM)

Heart Rhythm problems:

☐ Long QT Syndrome (LQTS)

☐ Short QT Syndrome

☐ Brugada Syndrome

☐ Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)

☐ Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)

☐ Marfan Syndrome (Aortic Rupture)

☐ Heart Attack, age 50 or younger

☐ Pacemaker or Implanted Defibrillator

Explain "Yes" answers here:_____

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

Signature of parent/guardian_____ Date_____

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[redacted]

Child's First Name_____ Last Name_____

Birth Date_____ ☐Male ☐Female

Parent/Guardian Name_____ Phone_____

Address_____ Apt. #_____ City_____ State_____ Zip_____

Cell Phone_____ Work Phone_____ Email:_____

Alternative contact name_____ Alternative phone_____

Health History

General health of your child: ☐Good ☐Fair ☐Poor ☐Explain_____

_____

Has either parent ever been diagnosed with diabetes? ☐Yes ☐No

Did child's mother have diabetes while pregnant? ☐Yes ☐No If yes, please provide birth weight_____

PLEASE CIRCLE if your child has ever been diagnosed with the following:

Asthma	Heart Defect/Disease	Diabetes	Hypertension
Frequent Ear Infections	Seizure or Convulsions	Bleeding/Clotting Disorders	Seasonal Allergies

Other:_____

Operation or serious injuries (dates)_____

Physical Examination: [redacted]

Height: ft in/cm		Blood Pressure:
Weight:	BMI %:	Heart Rate:
Immunizations status: ☐Current ☐Not current		Last Tetanus (date):
Has received COVID-19 vaccination: ☐Yes ☐No		

Sensory Screen
Vision normal? ☐Yes ☐No
Right: Left:
Hearing/Speech normal? ☐Yes ☐No

	Normal	Abnormal	Comments
ENT			
Teeth			
Neck			
Heart			
Lungs			
Abdomen			
Skin			
Extremities			
Spine			
Vascular			
Neurology			
Sexual Dev.			

Development Assessment
Is development appropriate for age ☐Yes ☐No
Referred to:
Sport Restrictions? ☐Yes ☐No
If yes, specify limitations:

Clearance for 2024 Camp, School & Physical Activity? ☐**Yes** ☐**No**

Medical Provider's comments:_____

_____

NATIVE HEALTH Provider signature_____ date_____

Print name_____