2021 Kawerak Youth Culture Camp

Culture Camp is an opportunity for youth ages 14-19 to gather in an outdoor setting to participate in cultural activities, and learn about the cultures of the Bering Strait Region. Culture Camp will take place at the Nuuk Camp outside of Nome, from **July 26-30 2021.**

All application materials must be returned to

Katirvik Cultural Center by

July 9, 2021.

Fax: 443-4452 or E-mail: kcc.staff@kawerak.org

- Participants will be selected based on a variety of factors; not first come first serve. However, you are encouraged to get your application in ASAP.
- You will be notified by July 16 of your application status and receive additional camp and flight information if accepted.
- Campers from outside Nome will travel to Nome the morning of July 26 and return home the afternoon of July 30.
- All travel, food, and lodging will be provided by Kawerak.
- Cell phone service is limited. We will have a satellite phone in case of an emergency. If you have a family emergency while your child is at camp you will be able to contact Kawerak's front desk at 443-5231 to pass along information.

Please contact us with any questions:

Lisa Navraq Ellanna
KCC Director
kcc.dir@kawerak.org
907-443-4340

Tanya Wongittilin
Project Assistant
twongittilin@kawerak.org
907-443-4342

Rebecca Ananuk Luce
Curator of Educational Programs
rsherman-luce@kawerak.org
907-443-4343

KATIRVIK CULTURAL CENTER | KAWERAK, INC. | RASMUSON FOUNDATION

Youth Culture Camp Applicant Information

Name: _____

Last First Indigenous Name

_____

Date of Birth Age Gender

Address: _____

Mailing address or post office box number

_____

City/Village State ZIP Code

Phone: _____ *Email* _____

Parent/Guardian and Emergency Contact Information

Name: _____

Last, First Relationship to Participant

Home Phone: _____ *Email* _____

Work Phone: _____ *Cell Phone* _____

Emergency Contact Name: _____

Last, First Relationship to Participant

Home Phone: _____ *Email* _____

Work Phone: _____ *Cell Phone* _____

Medical Information:

The following information is needed by any hospital, medical practitioner or first responder not having access to the participant's medical history:

Do you currently have or have a history of:

1.	Asthma/ Respiratory Ailments	☐ Yes ☐ No
2.	Diabetes	☐ Yes ☐ No
3.	Dietary Restrictions	☐ Yes ☐ No
4.	Epilepsy	☐ Yes ☐ No
5.	Heart Conditions	☐ Yes ☐ No
6.	High Blood Pressure	☐ Yes ☐ No
7.	Joint Injuries or Pain	☐ Yes ☐ No
8.	Recent Hospitalizations (last 5 years)	☐ Yes ☐ No
9.	Taking Prescription Medication	☐ Yes ☐ No
10.	Gastrointestinal disturbances	☐ Yes ☐ No
11.	Head Injury or history of concussions	☐ Yes ☐ No
12.	Hepatitis or other liver disease	☐ Yes ☐ No
13.	Dizziness or fainting episodes	☐ Yes ☐ No
14.	Bleeding or blood disorders?	☐ Yes ☐ No
15.	Are you currently in, or have you had, psychotherapy with a mental health professional?	☐ Yes ☐ No
16.	Disorders of the urinary or reproductive tract?	☐ Yes ☐ No
17.	Contact Lenses/Glasses	☐ Yes ☐ No
18.	Tobacco use?	☐ Yes ☐ No

If you answer yes to any of the above, or if you have any other condition that would be important for trip leaders or health providers to know, please give a brief explanation below: All information will remain confidential.

_____

_____

Allergies and Medications

19. Any Allergies? Insects, bee stings, food allergies, etc. Please list below: ☐ Yes ☐ No
20. Have you been hospitalized for allergies? ☐ Yes ☐ No
21. Do you carry epinephrine? ☐ Yes ☐ No

Allergies	Reaction	Treatment

22. Are you on any medications?: Please list medication below:

Medication(s)	Dosage	Side Effects

Swimming Ability

23. Please check box that applies to your swimming ability.

☐ I am very comfortable swimming	☐ Able to swim, but not very well	☐ Unable to Swim

This information provided above is a complete and accurate statement of any physical or psychological conditions which may affect my participation on this trip.

I have truthfully completed this form to the best of my knowledge and not withheld information that would be helpful to Kawerak acting in loc parentis for the duration of the trip. I realize the failure to disclose information could result in harm to myself or fellow students. I agree to inform Kawerak should there be any changes in my health status prior to the start of the course.

Participant Signature: _____ *Date:* _____

Parent/ Guardian Signature: _____ *Date:* _____

Participant Application

Why would you like to attend Culture Camp?

_____

_____

_____

_____

_____

List your hobbies/what do you like to do in your free time?

_____

_____

_____

_____

_____

What would you like to learn at Camp?

_____

_____

_____

_____

_____

Please list any other camps you have participated in:

_____

_____

_____

Culture Camp Agreements

As a participant of Culture Camp I understand and agree to the following:

	Initial
• I will respect and follow the Camp Rules, as explained to me by my camp staff;	_____
• I am responsible for my own actions and will act in a mature manner at all times;	_____
• I agree to attend and participate in all scheduled activities, including my share of chores with a healthy attitude;	_____
• I will NOT use alcohol, tobacco or other drugs during this gathering;	_____
• I will honor the schedule: therefore, I will NOT be leaving the gathering, unless as a part of an organized activity;	_____
• I will be accountable for my whereabouts at all times and will keep a staff person informed of my plans and activities;	_____
• I give permission for images and/or video of myself to be used for any news, promotion, and education materials produced by Kawerak or related agencies;	_____
• I understand that I will be sent home if I do not cooperate.	_____

Release: I understand that there are inherent risks involved in camping and with camp activities at Culture Camp. I understand that Kawerak, Inc. does not warrant, guarantee, promise or make any representations as to the condition of the camp site or any facilities, equipment, or other improvements thereon, or the fitness thereof for any purpose. I hereby release, discharge and hold harmless Kawerak, Inc. and/or Solomon Traditional Council, their officers, directors, employees, agents, representatives, successors and assigns, of and from and all liability, claim, demand or action, arising from or related to bodily injury or personal injuries know or unknown, death, or property damage resulting from my participation at Culture Camp. I personally assume all risks and take full responsibility for my participation and any resulting loss or damage to persons or property while participating at the Culture Camp.

Indemnification: I hereby agree to defend, indemnify and hold harmless to the fullest extent of law Kawerak, Inc. and their officers, directors, employees, agents, representatives, successors and assigns against third party claims related to my participation at the Culture Camp, to the extent of my own negligence or fault.

Authorization for Emergency Treatment: I, the undersigned participant, or parent, guardian or custodian if the participant is under 18, hereby consent to and authorize the administration and performance of all needed medicines, surgical treatment, anesthetic, or other medical treatment, which, in the opinion of the attending physician, may be necessary and advisable in the event of any medical emergencies to the participant. I further consent to and authorize first responders, including persons on site at the camp, to administer initial emergency medical treatment (first aid) in the event of such emergency. It is understood that efforts shall be made to contact the undersigned parent, guardian or custodian (if applicable) prior to rendering emergency treatment to the participant.

I have read and herby agree to abide by the above terms and conditions.

Participant Signature: _____ *Date:* _____

I have read and discussed with my child the above participation agreement terms and conditions and the consequences of violating the agreement.

Parent/ Guardian Signature: _____ *Date:* _____

Authorization for Use of Images or Video

Participant Name: _____

_____ Yes, I give authorization for images and/or video of my child to be used for any news, promotion, or education materials produced by Kawerak or related agencies.

_____ No, I do not give authorization for images and/or video of my child to be used for any news, promotion, or education materials produced by Kawerak or related agencies.

NSHC Authorization to Use and Disclose Health Information

(Norton Sound Health Corporation to Release Information to Other Party)

Patient

Patient Name: _____ Birth Date: ____/____/____ Ph. #: ____/____/____

Address: _____ Medical Record # _____

From

I authorize Norton Sound Health Corporation (NSHC) to disclose Patient's health information as describe below

To

Health information is to be disclosed to and received and used by:
Fill in the name of the person or facility with an address, number & a fax number

Name/Facility or Self: Kawerak, Katirvik Cultural Center *Phone Number: 907 / 443 / 4342*

Address: PO Box 948, Nome, AK 99762 *Fax Number: ____/____/____*

I Authorize, Tanya Wongittilin of Kawerak, if I'm unable to pick up my medical records. (I.D required from both parties)

*Select Format: ☐ Paper Form ☐ Secured Compact Disc (CD)

Purpose

For the purpose(s) of: ☐ At my request ☐ Other purposes (specify each purpose): verification of negative TB

For attendance to Kawerak Youth Culture Camp, July 26 – 30, 2021

Information to be Disclosed

Description or nature of information to be disclosed and includes information in any medium, including paper, electronic, and verbal information: (check all that apply)

- ☐ Discharge summaries
- ☐ History & physical exams
- ☐ Consultations
- ☐ Operative reports
- ☐ Physician progress notes
- ☐ Nursing notes
- ☐ Medication records
- ☐ Pathology reports
- ☐ Radiology & imaging reports
- ☐ Laboratory reports
- ☐ EKG Reports
- ☐ Emergency Dept. records
- ☐ Billing statements
- ☐ Clinic or office notes

Specially Protected Information about:
(must be checked to be disclosed):

- ☐ Mental health treatment
- ☐ Drug/alcohol abuse diagnosis, treatment, & referral
- ☐ HIV / AIDS Information

☐ Records for the following dates or treatment: _____
(Specify the information you are requesting with the Months, Dates, and or Years)

☐ ALL MEDICAL RECORDS: Most recent TB screening results
All health records from NSHC (Minimum Necessary for purposes of disclosure) (Excludes the above Specially Protected Information unless box(es) checked.)

Notices

1. There is the potential for information disclosed under this authorization to be re-disclosed by the recipient and no longer protected by federal or state privacy laws. But, if the information being disclosed under this authorization includes HIV/AIDS, mental health, and drug/alcohol abuse information, then federal or state law may prevent the recipient from re-disclosing this information.

2. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for purposes of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations, or if the services related to the information to be disclosed are performed solely for the purpose of providing that information to someone else.

3. I may revoke this authorization at any time by notifying, in writing, the Director of Health Information Management of NSHC; however, any such revocation will not apply to any disclosure or action already undertaken based on this authorization.

4. I will receive a copy of this authorization after it is signed. I may inspect or request copies of information disclosed by this authorization.

Dates

Unless revoked, this authorization is valid for the following time period:

Beginning date: ____/____/____ Ending (expiration) date: ____/____/____

Signature

SIGNATURE: I have read this authorization; I have had an opportunity to ask questions; I understand this authorization; and I willingly am signing this authorization.

_____ *Date:* ____/____/____
Signature of Patient or legal/personal representative

If not signed by Patient, Authority to sign on behalf of Patient: _____
(Specify relationship to the Patient)