Please fully complete this application by writing in print. Form should be completed by a parent or guardian. All information will be held in confidence and is required to ensure a safe, enjoyable, and positive experience while at camp.

I. CAMPER'S PERSONAL INFORMATION

Camper's Name_____ Date of Birth _____
Nickname _____
Address _____
Street City State Zip Code
Phone:
Home # (___) _____ Hours: _____ Work: (___) _____ Hours: _____

Age: _____ Sex: Male or Female

Shirt Size: (circle) Adult OR Youth (check one) ___Small ___ Medium ___ Large ___ X-Large ___ XX-L ___ XXX-L

II. CAMPER'S PRIMARY OR FAMILY DOCTOR

Name_____
Address _____
Street City State Zip Code
Phone:
Office # (_____) _____

III. PARENT OR GUARDIAN INFORMATION

Name_____ Relationship_____
Address _____
Street City State Zip Code
Phone:
Home # (_____) _____ Cell: (_____) _____

IV. EMERGENCY CONTACTS

1. Name_____ Relationship_____
   Address _____
   Street City State Zip Code
   Phone:
   Home # (_____) _____ Cell: (_____) _____

2. Name_____ Relationship_____
   Address _____
   Street City State Zip Code
   Phone:
   Home # (_____) _____ Cell: (_____) _____

V. CAMPER'S PROFILE

Nature of Disability/Primary Condition: _____

Please check/fill in all that apply:

Weakness/Paralysis: Left _____ Right ____ Upper ____ Lower _____ Total _____
Lung/Breathing Problem, describe: _____
Diabetic _____ Arthritis _____ Hemophilia _____ Amputation _____
Skin problems, describe: _____

Please check all the camper will bring:

Physical Support
Wheelchair _____ Power/Manual _____ Braces_____ AFO's _____ Splints _____
Walker _____ Cane _____ Other:_____
Please explain special needs or instructions related to assistive devices: _____
_____

Equipment:

_____ Catheter _____Bedpan _____ Urinal _____ Gait Belt
_____ Collection bag _____Ostomy/Stoma supplies
_____ Hearing Aide _____ Eyeglasses _____Contact Lenses
_____ Braces _____ Helmet _____ Splints
_____ Prosthesis, describe: _____
_____ Eating/Feeding supplies, describe: _____
_____ Other: _____

Please explain any special needs or instructions related to assistive devices: _____
_____

Please be sure to **SEND EXTRA SUPPLIES, clothes, bedding (absorbent pads, diapers, etc.)that will be needed during camp. Please **LABEL ALL SUPPLIES AND ASSISTIVE DEVICES** that are sent. **

VI. PERSONAL HISTORY

Height _____ Weight _____
Approximate cognitive/mental age _____
Unique behaviors/suggested ways to deal with behaviors, describe: _____
_____

Personal Care – Please state how you help your child with:
Eating _____
Drinking _____
Grooming _____

Washing/bathing _____
Dressing _____
Toileting _____

Please **CIRCLE** all that apply –

Bladder Control: Independent Needs Assistance, describe _____
Continent Incontinent: Day or Night
Indwelling Catheter Intermittent Cath – Times: _____
Condom Cath Ostomy/Stoma
Needs reminders

Bowel Control: Independent Colostomy
Bowel Program, describe: _____
Level of assistance, describe: _____

Aides used: None Urinal Bedpan Commode Chair
Attends/Diapers Other: _____

Diet: Regular Modified (Describe) _____ NPO Tube Feeds
Liquids No Liquids Thin Nectar Honey
If patient takes liquids, what does patient drink from?_____
Diabetic? Describe needs: _____
Bedtime snack? _____
Dietary Restrictions/Allergies/Thickener? _____
Adaptive equipment used/Feeding Assistance needed (ex. cut up food, needs help being fed, etc)
_____

Hearing: Normal Hearing Loss Mild Moderate Profound
If patient has hearing loss, any amplification?_____

Communication: Verbal Nonverbal Combination of verbal/nonverbal

If verbal, how does patient typically communicate?
Sentences Phrases Single words

If patient is nonverbal, how does patient typically communicate?
Gestures Sign Language Picture Board Device

Any other information regarding communication? _____

Vision: Normal Partial Legally Blind Total Loss

Sleeping: Sleepwalk? Yes or No
Need to be awakened during the night (ex. To use the restroom, etc)? Explain _____
_____
Require Extra rest? Yes or No Explain_____

Mobility: Impulsive? Yes or No Needs Redirection? Yes or No

Walking:	Independent	Stand-by	Some Assistance (gait belt)	Total/Dependent
Running:	Independent	Stand-by	Some Assistance (gait belt)	Total/Dependent
Sitting:	Independent	Stand-by	Some Assistance (gait belt)	Total/Dependent
Standing:	Independent	Stand-by	Some Assistance (gait belt)	Total/Dependent

Please describe level of assistance: _____

Transfers: Independent Stand-by Some Assistance (gait belt) Total/Dependent (lift)
Other/Describe: _____

Swimming: Level of assistance needed for swimming:
Independent Supervision Hands on assistance Dependent
Equipment needed for swimming (please send): _____

VII. MEDICAL INFORMATION

List all allergies (food medicine, plants, insects, tape, iodine, latex, etc.). Please describe reactions and actions taken afterwards: _____
_____
Date of last reaction: _____

Are camper's immunizations up to date? Yes or No
Date of Camper's last tetanus shot: _____

Is camper currently under a doctor's care? Yes or No
Please explain what camper is being treated for: _____
Has camper had any recent hospitalizations or illnesses? Yes or No
Please explain: _____

Is camper prone to seizures? Yes or No
Rescue med for seizures: _____
Date of last seizure: _____
Please describe seizures (frequency, severity, causes): _____
_____
Are seizures under control? Yes or No How?_____

Please list any concerns (medical, behavioral or otherwise) of which we should be aware:
_____
_____
_____

ATTENTION CAMPERS WITH SPINA BIFIDA AND SPINAL CORD INJURIES
For camper's enjoyment, please complete rectal/bowel washout 1-2 days before camp

VII. MEDICATION RECORD

*****Please bring all medications labeled and in the ORIGINAL CONTAINER (this needs to be done even if camper is independent – ALL MEDS WILL BE LOCKED UP), complete with directions for their use. Also, remember to include enough for Camper's entire stay. *****

List all medications (prescription and non-prescription), dose and exact time to be taken:

MEDICATION	DOSAGE	TIME TO BE TAKEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any special needs for administration of medication (food, equipment, etc?) _____
_____
_____
_____

Name of Doctor who prescribed Medications: _____
Address _____

Office Phone # _____