

NW KIWANIS CAMP

CAMPER APPLICATION 2009

Return to: NORTHWEST KIWANIS CAMP
PO Box 1227
Port Hadlock, WA 98339

Questions? Please call 360-732-7222 or email to nwkc@earthlink.net

[For camp office use only]	
DATE RECEIVED: _____	DEPOSIT AMNT: _____
APPLYING FOR FINANCIAL ASSISTANCE: Y ___ N ___	
SESSION NUMBER: _____	
DDD CLIENT: Y ___ N ___	
CASEWORKER AUTH. RECEIVED: Y ___ N ___	
MEDICAL COUPON IN FILE: Y ___ N ___	
MEDICAL EXAM FORM RECEIVED: Y ___ N ___	

This confidential application must be completed in FULL for all campers and will be returned if incomplete. Each applicant will be assessed on an individual basis with consideration given to special circumstances. Acceptance is based upon the review of all required information. The Program Director and Nursing Director reserve the right to refuse or cancel enrollment of an individual whose needs cannot be safely and effectively met.

Session Preference: Please indicate your first choice with the number 1 (One) and your second choice with the number 2 (Two) beside the appropriate session.

- _____ Session #1 (ages 6-20 yrs) Noon July 13 to Noon July 17
- _____ Session #2 (ages 36 and older) Noon July 20 to Noon July 24
- _____ Session #3 (ages 17 -35) Noon July 27 to Noon July 31
- _____ Session #4 (AAC Campers only ages 6-18) Noon August 3 to Noon August 07

Full Name: _____ **Birth date:** ____/____/____

Email: (required for notices) _____ **Age** _____

Mailing Address: _____ **County:** _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** (____) _____

Group Living Facility (if applicable) _____ **Phone:** (____) _____

Sex: M or F (circle) **Race:** _____ **Custody Status:** Independent **Parent** **Other**

Disability: Primary _____ **Secondary:** _____

Other issues? _____

Parent/Guardian/Spouse Name: _____

Address (if different) _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** (____) _____

Place of Employment _____ **Phone:** (____) _____

Emergency Contacts (Other than above)

1. **Name:** _____ **Relationship:** _____

Day Phone: (____) _____ **Night Phone:** (____) _____

2. **Name:** _____ **Relationship:** _____

Day Phone: (____) _____ **Night Phone:** (____) _____

Physician's Name: _____ **Phone:** (____) _____

Health Insurance Carrier: _____ **Policyholder:** _____ **Policy#:** _____

Person/Agency responsible for payment: _____ **Phone:** (____) _____

Address: _____

A \$50.00 non-refundable deposit MUST accompany this application. If using DSHS or other agency funding, a letter of authorization from the caseworker must accompany the application.

Please Indicate Shirt Size (check child/adult, circle one size): [CHILD] ___ S M L [ADULT] ___ S M L XL XXL

Financial assistance through the Northwest Kiwanis Camp is limited to \$250.00. Please call us to request an application. _

NW KIWANIS CAMP

**CAMPER APPLICATION 2009
DAILY LIVING INFORMATION**

Camper Name: _____

Nickname: _____

Height: _____ Weight: _____ Date of last height and weight check: _____

Approx. Cognitive Age (school grade/age appropriate): _____

Approx. Functional Age (daily living skills/age appropriate): _____

HEARING: Does the Camper have normal Hearing? Yes _____ No _____ Percentage of hearing loss: _____

If "NO", please tell us what the issue is and how we can work with the camper. _____

SPEECH: Does the camper use normal English Language? Yes _____ No _____

If "NO", please tell us what form of language your camper uses and how we might best communicate with the camper:

Does the camper use an AAC Device? If so, which one? _____ PEC Boards? _____

If yes, please bring the boards and/or devices to camp _____

DIETARY : Is the camper allergic to any foods: If yes, please list: _____

Is the camper on a special diet? If yes, please provide details on the back of this sheet _____

Is the camper tube-fed?

VISION: Does the camper have normal Vision? Yes _____ No _____ Wears glasses? Yes _____ No _____

If "No", please tell us the degree of loss: _____

MOBILITY: Does the camper use a device that helps with mobility? Yes _____ No _____

If yes, please list the devices the camper uses (ex. wheelchair, walker, other, etc.) _____

Note: Mobility device/s must be brought to camp with you.

TRANSFERS: Does the camper need transfer assistance? Yes _____ No _____

If "Yes", what kind of assistance is needed: _____

Will the camper be bringing adaptive devices with him/her to camp? Please check all that apply.

None _____ Braces _____ Night Braces _____ Splint _____ Retainer _____
Prosthesis _____ Glasses _____ Hearing Aid _____ Dentures _____
Shunt _____ Helmet _____ Other _____

TOILET: Is toileting an issue for the camper? Yes _____ No _____ Diapers? Yes _____ No _____

Catheter: Yes _____ No _____ Colostomy: Yes _____ No _____ Aids used? Yes _____ No _____

If yes please tell us what assistance is required: _____

WASHING AND DRESSING: Does the camper need any assistance with washing and dressing? Yes _____ No _____

If yes what assistance is needed _____

SLEEPING: Does the camper have difficulty sleeping when away from their usual sleeping environment? Yes _____ No _____

If "Yes", please explain sleep issues: _____

HEALTH HISTORY

Camper Name: _____

An individual may not be considered for enrollment if he/she is determined to have a medical condition associated with a high risk for complication or injury.

Does or has the applicant ever had, any of the following: *(record month and year where applicable)*

SEIZURES: None _____	Petit Mal _____	Grand Mal _____	Other _____
Severity: _____	Frequency: _____	Most Recent: _____	

	Month/Year		Month/Year		Month/Year
Arthritis		Bleeding Disorder		Chicken Pox	
Ear Infections		Hypertension		Measles	
Heart Defect		Mononucleosis		Rubella	
Diabetes		Decubitis Ulcer		Mumps	

Is the applicant subject to any of the conditions listed (circle those that apply):

Ears	Eyes	Nose	Throat	Nails	Scalp	Skin
Skeletal	Constipation	Abdomen	Heart	Stomach Upset	Kidneys	Lungs

Recommendations: _____

ALLERGIES:	Type	Mild	Severe
Drugs			
Insects			
Pollens			
Foods			
Asthma			

If reaction occurs: _____

IMMUNIZATION HISTORY

(Write month/year of basic immunization, and most recent booster, or you must write "current" or "dates unknown" and initial)

	Date		Date		Date
DPT		Rubella		T.B. Test	
Polio		Small Pox		Mumps	
Measles		Tetanus		Hepatitis B	

SURGERIES/SERIOUS ILLNESS (give dates):

Camper Name: _____

CHRONIC OR RECURRING ILLNESS:

OTHER CONDITIONS OR ISSUES WE SHOULD BE AWARE OF?

Is the camper a “runner”? Yes _____ No _____

Is the camper taking any prescription medications or over-the counter medications? Yes _____ No _____

Please complete the Medication List Form for any medications the camper will be taking during camp sessions.

ALL MEDICATIONS MUST BE IN THE ORIGINAL CONTAINERS!

Please verify that the quantities you bring to camp are sufficient for five days as we cannot process refills.

PERSONAL CAMPER INFORMATION

Camper Name: _____

Activities to be encouraged:

Activities to be limited:

A camper-counselor ratio of one-on-one is not guaranteed.

Does the camper require one-on-one total care and supervision? Yes _____ No _____

If yes, explain: _____

Note: At managements' discretion, an attendant may be required to accompany a total-care camper.

Is the camper an independent adult requiring no supervision? Yes _____ No _____

In your opinion, under supervision, may the camper participate in:

Swimming Program Yes _____ No _____ Comments: _____
Horseback Riding Program Yes _____ No _____ Comments: _____
If Down Syndrome: Atlanto-Axial Subluxation? Yes _____ No _____
Cervical X-Ray for Atlanto-Axial Subluxation? Positive _____ Negative _____ X-Ray Date: ____/____/____

Additional medical contraindications may apply to riding. Alternative horse-related activities may be offered.

Has the camper attended Northwest Kiwanis Camp before? YES _____ NO _____

When? _____

Referred By: _____

List Interests, Hobbies, Activities, School Clubs, etc... _____

Expectations/Goals for this camping experience: _____

Does the camper sunburn easily? Yes _____ No _____

Name of person completing this application: _____

Relation to applicant _____

Permission to Treat (Standards HW-7, HW-23)

Camper's Full Name _____

I hereby give permission to the Northwest Kiwanis Camp medical personnel to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation. In the event I cannot be reached in an emergency, I hereby give permission to the healthcare provider selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Over-the-counter medications

I hereby give permission for the Northwest Kiwanis Camp to administer the following over-the-counter medications if the nurse deems it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise.

Headache	Tylenol or ASA	Diarrhea	Anti-Diarrhea
Upset Stomach	Pepo Bismal	Itching	Calamine Lotion or CortAid
Menstrual cramps	Ibuprophen	Skin infections	Triple Antibiotic Ointment

OM-19

Procedures regarding camper release:

Campers will only be released to authorized persons during camp or at noon on the last day of the camp. Persons authorized to pick up the above named camper are:

- 1. _____
- 2. _____

I understand that if the above named camper is not picked up by noon on the last day of camp, I may be subject to an extra charge.

The NW Kiwanis Camp Director will verify cause of absentees or 'no-shows' by contacting the above parent/guardian and or persons listed as emergency contacts on the camper application form.

I hereby give permission to the Northwest Kiwanis Camp for Permission to Treat, Over the Counter Medication and Procedures Regarding Camper Release and NW Kiwanis Camp Policies and Procedures.

I also agree to furnish NORTHWEST KIWANIS CAMP Programs with the Physical Examination Report, signed by a licensed physician, at least two weeks prior to the opening day of camp. I understand that the camper will not be allowed to attend without this form. [Medical exam required every two years.]

This Health History is correct to the best of my knowledge, and the applicant described herein has permission to engage in all program activities except as noted. I also give permission to the medical personnel selected by the Director to order x-rays, routine tests and treatment for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the healthcare provider selected by the Director to hospitalize, secure proper treatment, order injections, anesthesia, or surgery for me/or my child as named above. This form may be photocopied for use out of camp.

In consideration for acceptance, I hereby release and waive any claim, cause or action which may accrue against the NORTHWEST KIWANIS CAMP, any employee thereof, or any other persons acting with their permission, arising from injury during his/her stay at the KIWANIS CAMP site from said facility, or during any activity approved by any of said persons.

I hereby give permission to the NWKC to use any photographs, video or film in which he/she may appear: Yes _____ No _____

Adult Camper: _____ Witness: _____

Signature of Parent/Guardian/: _____ Date: _____

(360) 732-7222
P.O. Box 1227
Port Hadlock, WA 98339

MEDICATION LIST

Campers Name: _____ **Session:** _____

Campers that have filled out this form and mailed it to the above address no later than 10 days before the camp session will only need to present the medications (in the original prescription containers- with prescription labels matching the names and dosages below). This will save a great deal of time at camp check-in! Campers with no medication will save even more time.

- **Please** note that vitamins, minerals, and herbs will be considered "medication" and must be accompanied by a doctor's prescription.
- **Please** list the camper's medication, precise dosage, and daily frequency from the prescription label.

Example: Depakote 750 mg twice daily (a.m., bedtime)

- **Please** make notation of any suggestions that make medication administration an ordinary and more everyday experience at camp.
