

2011 Camper Application Checklist

Please use this checklist as a guide in filing out the attached application.

DID YOU?	Yes	NO (Expected submission date)
1. Complete all Campers Vital Information (name, address, DOB, age, sex, phone number)		
2. Include a recent photo of the camper		
3. Fill in both choices for a camp date		
4. Sign the Emergency Authorization Permission Form		
5. Include the Medical/Physical History Forms If No- When will this information be returned to Camp Courageous?		
6. Complete the Profile and Communication sections		
7. Complete the Health History Form and Medications Form		
8. Include the Activities of Daily Living so that we can best serve the needs of each individual camper		
9. Thoroughly read and Sign the Insurance Waiver Form		
10. Thoroughly read and Sign the Fee Form		
11. Include the Non-Refundable Processing Fee		

NOTE: ANY INCOMPLETE APPLICATION MAY NOT BE PROCESSED. THIS COULD RESULT IN EITHER BEING PLACED ON OUR WAITING LIST OR THE LOSS OF A RESERVED PLACE IN YOUR PREFERRED CAMP WEEK.

Please keep a copy of this checklist for your records, particularly if you are sending in a partial application.

If you have any questions, please call the office at 419-875-6828 or email chelseab@campcourageous.com.

Thank you for your attention on all aspects of the camper application. We can't wait to see your camper this summer!!



ATTACH RECENT PHOTO HERE

CAMP COURAGEOUS, INC 2011 Camper Application

Applicant Name: _____
Last First Nickname

Applicant Address: _____

_____ City County State Zip Code

Applicant Phone: _____ 2nd: _____

DOB: _____ Gender: Male ___ Female ___

Height: _____ Weight: _____ Age: _____

I would like to register for Session(s)

1st Choice: _____ 2nd Choice: _____ 3rd Choice: _____

Please indicate if you wish to attend more than one session. Attach an additional sheet if necessary.

PRIMARY CONTACT INFORMATION:

Primary Contact: _____ Parent ___ Guardian ___ Staff ___

Direct Care Facility: _____

Address: _____

_____ City County State Zip Code

Phone No: _____ 2nd: _____

Email: _____

Is the Primary Contact Address the preferred mailing address? _____

EMERGENCY AUTHORITY INFORMATION

Name

Phone Number

Primary Emergency Contact: _____

Secondary Contact: _____

Primary Physician: _____

Address: _____

Specialist or Clinic: _____

Address: _____

Dentist: _____

Medical Insurance: Yes No Insurance Carrier: _____

Policy or Group Number: _____ Medicaid/Medicare #: _____

I hereby give permission to the medical personnel selected by the Executive Director to order x-rays, routine tests and treatment for me /my child/or ward, and in the event that parent/guardian cannot be reached in an emergency, I hereby give permission to the Physician selected by the Executive Director or Nurse to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me /my child / or ward as named above. This form may be photocopied for use out of camp.

Signature of Parent/Guardian or Adult Camper or Direct Care Staff Person

Date

EMERGENCY TRANSPORTATION AUTHORIZATION

I hereby give Camp Courageous, Inc. Staff and/or Nurse permission to transport (insert Camper name) _____ to _____ for emergency care, or to _____ for emergency dental care, or to the nearest available source of assistance.

Signature of Parent/Guardian or Adult Camper or Direct Care Staff Person

Date

CAMPER PROFILE

The information you supply below is VERY IMPORTANT in caring for the campers and making group, camper/counselor assignments. PLEASE BE AS SPECIFIC AS POSSIBLE

Disability Information:

Primary Disability: _____

Secondary Disability (ies): _____

Developmental Age Functioning Level: _____

COMMUNICATION ABILITIES

	Normal	Impaired	Limitations
Hearing Ability	_____		
Vision Ability	_____		
Time-Concept	_____		
Memory	_____		
Other communication Difficulties	_____		
Uses communication Board/System	YES	NO	_____
Verbalizes, may be difficult to understand	YES	NO	_____
Non-Verbal – yes/no responses only	YES	NO	_____

Social Interactions	YES	NO
Likes One-One Interaction	_____	_____
Likes Small Group Interaction	_____	_____
Likes Large Group Interaction	_____	_____
Has camper ever been away from home before?	_____	_____

Level of Supervision	
Likes Physical Interaction	_____
Needs verbal prompting/cueing to understand and follow basic instructions	YES NO
Understands and can follow basic instruction	YES NO

Medical/Physical History

To Be Completed By A Medical Physician only!

Date of Exam: _____ Male: _____ Female: _____

Camper's Name: _____ D. O.B. _____

Medical Diagnosis: _____

Weight: _____ B/P: _____ Pulse: _____ Resp: _____

Tetanus Shot: Yes _____ No _____ Date: _____

TB Skin Test: Date _____ Result: _____

Please indicate if camper has/had a history of the following secondary problems by checking yes or no. If YES, please include COMPLETE information pertaining to the problem.

PROBLEM	YES	NO	IF YES PLEASE DESCRIBE
Learning/Mental Impairment	___	___	_____
Psychological Impairment	___	___	_____
Auditory Impairment	___	___	_____
Hearing Aids:	___	___	_____
Speech Impairment	___	___	_____
Heart Defect/Disease	___	___	_____
Hypertension	___	___	_____
Postural Hypertension	___	___	_____
PVD	___	___	_____
Asthma/COPD	___	___	_____
Diabetes	___	___	_____
Insulin Dependent	___	___	_____
Kidney Disease/Impairment	___	___	_____
Bleeding/Clotting Disorders	___	___	_____
Hemophilia	___	___	_____
HIV+	___	___	_____
Blood/Body Fluid Precaution	___	___	_____
Hepatitis	___	___	_____
Gastrointestinal Disorder	___	___	_____
Pain	___	___	_____
Controlled	___	___	_____
Affected Areas	___	___	_____
Arthritis	___	___	_____
Contractures	___	___	_____
Fractures	___	___	_____
Location	___	___	_____
Healed	___	___	_____
Spinal Column Injury	___	___	_____
Date/Type _____	___	___	_____
Head Injury	___	___	_____
Date/Type _____	___	___	_____
Joint Disease/Deformity	___	___	_____
Scoliosis	___	___	_____
Degree/Type _____	___	___	_____
Hydrocephalus	___	___	_____

Seizures: YES ___ NO ___ Type: _____ Controlled: YES ___ NO ___
 How Often? _____
 Does Respiratory Difficulty occur? YES ___ NO ___ Describe _____

Skin Care: Any existing open areas? YES ___ NO ___
 If yes, please describe size, location and care: _____

Allergies: Drugs: YES ___ NO ___ If yes, list: _____
 Foods: YES ___ NO ___ If yes, list: _____
 Environment: YES ___ NO ___ If yes, list: _____

Recent Illness/Injury: YES ___ NO ___ Type: _____
Surgery: YES ___ NO ___ Type: _____
Other: YES ___ NO ___ Type: _____

Additional Information: Please use this space to tell us any other medical information or recommendations pertinent to this individual's participation in Camp Courageous programs:

Physicians Standing Orders

**NOTE: ALL OVER THE COUNTER MEDICATIONS MUST BE SUPPLIED BY THE CAMPER AND STORED WITH THE CAMPER'S PRESCRIPTION MEDICATIONS AT THE NURSES STATION.
CAMP COURAGEOUS, INC. WILL NOT SUPPLY OVER THE COUNTER MEDICATIONS.**

Please mark all items on this list that you wish your patient to receive while at camp. Write in any additions or changes that you would prefer.

Skin Protection:

___ YES ___ NO Camper can use Sunscreen
___ YES ___ NO Camper can use Insect Repellant

Fever or Discomfort:

___ Notify parents/physician if temperature is above 101.
___ Acetaminophen (2) Q 4 hours PRN (tablet or liquid)
___ Ibuprofen (2) Q 6 hours PRN for dysmenorrhea or muscle spasms
___ YES ___ NO Camper can take aspirin
___ YES ___ NO Camper can take Tylenol

Coughs or Nasal Congestion:

___ Robitussin or Benadryl Elixir Q 4 hours PRN as directed on the product label or as written below:

Antacid:

___ Maalox or other over the counter antacid as directed on product label or as written below:

Constipation:

___ MOM 30cc Q HS PRN
___ Dulcolax suppository, rectally PRN
___ Fleets enema PRN

Directions for use of suppository or enema (parents must supply if needed)

Physician's Name _____

Signature: _____

Telephone Number: _____ Date: _____

HEALTH HISTORY FORM

Please circle item(s) that pertain to this camper. Write dates where indicated.

Frequent ear infections	Yes	No	Mumps, Measles	Yes	No
Epilepsy	Yes	No	Heart Disease/Trouble	Yes	No
Asthma, Hay Fever	Yes	No	Diabetes	Yes	No
Hypertension	Yes	No	Other: _____		
Chicken Pox	Yes	No			
Allergies			Females Only		
Milk Products	Yes	No	Has this person Menstruated?	Yes	No
Poison Ivy	Yes	No	If no, is she aware of Menstruation?	Yes	No
Insects/bees	Yes	No	If yes, is her menstrual history normal?	Yes	No
Uses bee sting kit	Yes	No			
Other: _____					
If you answered YES to any of the above, Please explain:					

IMMUNIZATION

DATES

BOOSTER

Diphtheria, Pertussis, Tetanus
 Tetanus, Diphtheria, Tetanus
 Oral Polio, (sabin) TOPV
 Injectable polio (Salk)
 Measles (hard, red Rubella)
 Tuberculin Test Given
 Chicken Pox (varicella)

Seizures

Does the camper have seizures? Yes No How often: _____

How long does the seizure last? _____

Please describe the camper's behavior before and after a seizure:

Chronic Health Problems:

MEDICATIONS (attach additional sheets if necessary)

Will this individual be receiving prescription medication while at camp? If yes, please fill in the following and remember to bring all medications in their original prescription bottle.

Medication: _____
Dosage Amount _____ Time of Day _____ Purpose _____
Other Directions _____

Medication: _____
Dosage Amount _____ Time of Day _____ Purpose _____
Other Directions _____

Medication: _____
Dosage Amount _____ Time of Day _____ Purpose _____
Other Directions _____

Medication: _____
Dosage Amount _____ Time of Day _____ Purpose _____
Other Directions _____

Campers will be participating in outdoor recreation and leisure programs while at camp, please list any medical, or limiting conditions we should be aware of:

PLEASE remember to send extra supplies, clothes, sleeping bag and bedding, absorbent pads, diapers, glasses, hearing aid batteries, etc.

SIGNATURE OF PERSON COMPLETING FORMS:

DATE:

Adult Camper, Parent/Guardian, Direct Care Staff

Behavior and Behavior Management

Camper has a "Specialized Supports Plan" or "Behavior Plan" in place at work or at home?

YES NO

If YES, a copy of the Behavioral Support Plan must be on file prior to arrival at camp.

No camper will be admitted without a plan on file.

Camper exhibits repetitive, difficult or dangerous (to self or others) behaviors at home or elsewhere?

YES NO

Camper exhibits observable antecedents (warning signs) before episodes or behavior problems?

YES NO

Please describe behaviors, emotional problems, triggers and possible resolutions to the camper's behaviors:

Special behavior concerns and/or limitations:

Please describe the Behavior Management Techniques used:

Campers will not necessarily be excluded from this program because of any described behaviors. This information enables us to provide appropriate placement and to secure additional or specialized staffing if necessary. If camper requires 1:1 attention, special arrangements must be made with the Director. Please report any behaviors appropriately and adequately.

ACTIVITIES OF DAILY LIVING: Please be as specific as possible

EATING/DRINKING:

____ Independent ____ Needs food cut up ____ Foods Blended/Puree
____ Needs Assistant ____ Difficulty Swallowing ____ Must be fed via G-Tube

DIET:

____ Normal ____ Knows Limits ____ Low Salt
____ Low Calorie ____ Diabetic
____ Special Diet Note: Please contact our Camp Chef to discuss menu.
____ Food Allergies: please list: _____

MOBILITY:

____ Walks independently ____ Walks: Needs Assist
____ Must be assisted on rough areas
____ Wheelchair: needs assistance at all times ____ Wheelchair, but is independent in use

TRANSFERS: ____ Not applicable ____ Can make transfers
____ Pivot Transfers ____ Two person assistance ____ Must be lifted

DRESSES/UNDRESSES:

____ Independent ____ Needs assist with buttons/shoes/etc.
____ Needs total assistance ____ Needs only some help

SLEEPING: Camper is used to ____ hrs sleep at night

____ No special concerns ____ Gets up during night ____ Must be turned during night
____ Occasional Nightmares ____ Special night routine: _____

BATHROOM NEEDS:

____ Completely Independent ____ Needs transfer to toilet ____ Needs total assistance
____ Toilet Chair ____ Needs help with clothing ____ Urinal
____ Needs assist wiping ____ Diapers/Depends (Day or Nighttime) _____

SWIMMING:

____ Swims Independently ____ Must wear lifejacket ____ Needs full time help in water
____ Does Not Like to Swim

Comments:

Camp Courageous, Inc.

Insurance Waiver and Release of Liability

In consideration for participating in any way in Camp Courageous Inc.'s recreation program, camps, related events and activities, the undersigned:

Agrees that prior to participating, I and/or the minor participant will inspect the facilities and equipment to be used, and if they believe anything is unsafe will immediately advise Camp Courageous, Inc. of such condition(s) and refuse to participate.

Agrees that I have personal responsibility to follow established safety rules & procedures to the extent that I participate in such activities. If I have questions about activity, I have the responsibility to consult the counselor. Acknowledge and fully understand that I and/or the minor participant will be engaging in activities that involve risk of serious injury, including permanent disability, dismemberment and death, and severe social and/or economic losses which might result only from my own actions, inactions, the negligence of other campers, the rules of play, condition of the premises or any equipment used. Acknowledge and fully understand that there may be risks, beyond those mentioned in the foregoing, not known at this time or not reasonably foreseeable at this time.

Assume all of the foregoing risks and accept personal responsibility for any damages, claims, or losses following any loss of personal property, physical injury, permanent disability, dismemberment or death to myself and/or family member(s), including any minor children. Certify that myself and/or family member(s), including any minor children, are fully capable of participating in camp activities. Hereby forever release, waive, discharge, and covenant not to sue Camp Courageous Inc., its employees, volunteers, staff, agents, successors, assigns, trustees, and/or members, its affiliated clubs, their representative administrators, directors, coaches, other participants, sponsoring agencies, sponsors, advertisers, heirs, and if applicable, owners, and lessors of premises used to conduct the event, all of whom are hereinafter referred to as "release's", from demands, losses, claims or damages arising from injury to the above mentioned camper or his/her property caused or allegedly caused, in whole or in part, by the negligence of release's or otherwise, that occurs during camping sessions or activities, in transit to or from the camp, or during any activity approved by release's.

I/WE HAVE READ THE ABOVE WAIVER AND RELEASE, UNDERSTAND THAT I/WE HAVE GIVEN SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN, IT VOLUNTARILY.

Participant's Name:

Camper's Signature

Date

If participant is a minor and/or has a legal guardian, parent(s), and/or guardian(s), signature below is required:

Parent/Guardian/Direct Care Staff Signature

Date

Second Parent/Guardian/Direct Care Staff Signature

Date

Note: If second parent signature is not possible, first parent/guardian certifies that the second parent/guardian has authorized to pursue this activity and second parent/guardian agrees to all items stipulated above.

**Campers will not be admitted without a signed
Insurance Waiver and Release of Information on file.**

2011 Camp Courageous, Inc. Fee Form

In order for us to process your camp reservation, you MUST complete and return.

CAMP 2011 FEES (Does Not Include Non-Refundable Fees)

- \$743.04 Residential Week
- \$336.80 Residential Respite Weekend
- \$250.00 Adult Day Camp (Lott Industry Shut Down Week consumers only)
- \$240.00 Day Camp Fee (\$100 for sibs/friends- contact us for details)
- \$150.00 Summer Options eligible Day Camp Fee (Please contact Summer Options)

** Two Non-consecutive weeks must be billed as separate weeks now

** Two Weeks with Weekend Camps must be billed separately,

For Example: Session 2, Respite 2, Session 3

OR

Session 6, Respite 6, Session 7

Non-Refundable Administrative Fee

Day camp Fee - \$25.00 Residential Fee - \$50.00

(must be included with reservation and is a non-waiver fee - not part of the camp fee)

Camper Name: _____ Session #(s):First _____
Second: _____ Third _____

PAYMENT PLAN A- PARENT/GUARDIAN/CAMPER

Parents/Guardian/Camper will pay the fee of \$ _____

This will be paid as checked: _____ Payment in full enclosed Check #: _____ Date _____

OR

Charge Payment to: Master Card Visa Discover
Amt. of Charge: \$ _____ Credit Card #: _____ exp Date: ____/____
Name on account: _____
Signature on account: _____

Payments will be made as follows...

Date _____ Amount\$ _____
Date _____ Amount\$ _____
Date _____ Amount\$ _____

Private payments are due by the end of the camp session.

Late payments will be assessed a 5% late penalty for each 30 day period past due.

PAYMENT PLAN B- FAMILY RESOURCE SERVICES

Important! Complete this section, indicating how much each sponsor will provide and when the payment will be made. It is your responsibility to contact FRS representative prior to completing application. If you have a FRS Co-Pay it must be paid prior to the camping season!

Billing to FRS will be completed after attendance at camp. Be aware of the amount for camp that we will be charging against your account!

NAME OF AGENCY: _____
CONTACT PERSON: _____
ADDRESS: _____ CITY: _____ STATE: _____
ZIP: _____ PHONE: _____ FAX: _____

AMOUNT TO BE PAID BY Agency \$ _____ PAYMENT DATE: _____

If the sponsor listed below is only paying part of the camp fee, indicate who is paying the balance:

NAME OF SPONSOR: _____
ADDRESS: _____
CITY: _____ STATE _____ ZIP _____ PHONE _____
AMOUNT TO BE PAID BY SPONSOR \$ _____ PAYMENT DATE: _____

PAYMENT PLAN C- IO and MEDICAID WAIVERS

Residential camping program – Billing will run from Sunday 5:00 p.m. until Friday 3:00 p.m. for the camp week

I/O Waivers - will be billed at our standard ratio of 1:3. HPC will be billed at \$1.84 for 316 units totaling \$581.44. OSOC will be billed at \$1.01 for 160 units or 161.60

Total cost per week per person is \$743.04

Level One - The ADL rate will be \$185.76/day for four days and the weekend rate will be \$336.80

Weekend Camps – billing would be based on a 1:2 ratio for HPC units, to begin on Friday at 5:00 pm. to noon on Sunday, 108 HPC units @1:2 ratio, \$2.52 per unit, 64 OSOC Units @ 1:3 ratio, \$1.01 per unit, totaling \$336.80 for the weekend.

SASS Name, Phone and e mail:

Please contact the Camp Courageous, Inc. offices
to verify that the paperwork and information is complete and accurate.

camping@campcourageous.com or call 419 875-6828

**** Please note: Campers may require changes in ratios due to personal limitations (e.g. use of wheelchair) Adjustments to the ratios will be made accordingly, and the price of camp will need to reflect those adjustments. Please keep this in mind.**

SIGNATURE of PERSON COMPLETING FORMS

DATE