2012 Camper Application Checklist

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

DID YOU?	Yes	NO (Expected submission date)
1. Provide ACCURATE Emergency Contact Information		
2. Complete all Campers Vital Information (name, address, DOB, age, sex, phone number)		
3. Include a recent photo of the camper		
4. Fill in all choices for camp sessions		
5. Sign the Emergency Authorization Permission Form		
6. Include the Medical/Physical History Forms		
7. Complete the Profile and Communication sections		
8. Complete the Health History Form and Medications Form		
9. Include the Activities of Daily Living so that we can best serve the needs of each individual camper		
10. Thoroughly Read and Sign the Insurance Waiver From		
11. Complete and Sign the FEE FORM		
12. Include the Non-Refundable Administration 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 and application 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
2012 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 of 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

Additional Information:

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

Milk Products	Yes	No
Poison Ivy	Yes	No
Insects/bees	Yes	No
Uses bee sting kit	Yes	No

Other:______________________________

Females Only

Has this person Menstruated?	Yes	No
If no, is she aware of Menstruation?	Yes	No
If yes, is her menstrual history normal?	Yes	No

If you answered YES to any of the above, Please explain:

____

____

____

____

____

____

IMMUNIZATION

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

Seizures

Dos 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 leasers of premises used to conduce 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.

2012 Camp Courageous, Inc. Fee Form
In order for us to process your camp reservation, you MUST **complete and return.**

CAMP 2012 FEES *(Does Not Include Non-Refundable Fees)*

Residential WeekCamp
- **I/O Waiver- $749.65**
- **Level 1 Waiver and Private Pay- $743.04**

Residential Respite Weekend
- **I/O Waiver- $299.86**
- **Level 1 Waiver and Private Pay- $336.80**

Adult Day Camp- $229.50
Children's' Day Camp Fee
- **Summer Options Eligible- $165.00 (Please contact Summer Options for details)**
- **Private Pay- $255.00**

Non-Refundable Administrative Fee
Day camp Fee - $35.00 Residential Fee - $75.00
(must be included with application 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 Camper Billing – Billing will be based on the time the camper is dropped off/picked up with the anticipated times being: Sunday at 4:00 pm until Friday at 3:00 pm

- **Level 1 Waiver- 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 for a total cost of 743.04.**
- **I/O Waiver – (5) days of Community Respite will be billed at the daily rate of 149.93 for a total cost of 749.65 **Note this is a change from prior years due to new ODMRDD Rule 5123:2-9-34 for individuals with IO Waivers**

Weekend Camps – Billing will be based on the time the camper is dropped off/picked up with the anticipated times being: Friday at 5:00 pm until noon on Sunday.

- **Level 1 Waiver - 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, for a total cost of $336.80**
- **I/O Waiver – (2) days of Community Respite will be billed at the daily rate of 149.93 for a total cost of 299.86 **Note this is a change from prior years due to new ODMRDD Rule 5123:2-9-34 for individuals with IO Waivers**

SASS Name, Phone and email:

Please contact Chelsea Banas
to verify that the paperwork and information is complete and accurate.
chelseab@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