

Annual Information Form for Camp New Hope, Inc. (2018)

Form must be filled out completely.

All important information relative to the camper's health and well-being should be on this annual information form. Please DO NOT rely on verbal instructions at the time of check-in to communicate important information about your camper. Please remember that even though your camper may have attended many times, their counselor may be new and does not know about your camper and their required care. This information helps us to provide the best care for your camper.

NEW Campers ONLY Photo

Please use a CURRENT photo (shoulder and up face shot) of your camper. These will be used for camper badges.

Camper Information

Camper Name: _____ Preferred name, if any: _____

Age: _____ Date of Birth: ____/____/____ Weight: _____ Height: _____ Gender: Male Female

Who does the camper live with? Check all that apply: Mom Dad Other Family Member Group Home On Own

Diagnosis: (Check & describe all that apply) Cerebral Palsy Autism Down Syndrome

Intellectual Disability: Mild Moderate Severe

Speech Impairment: Verbal Hard to Understand Non-verbal Sign Language/Signs Communication Device

Visual Impairment: Blind Some Sight Night Blindness

Hearing Impairment: Deaf Some Hearing Hearing Aides

Behavioral Disorder _____ Mental Illness: _____

Physical Limitations: _____ Learning Disability: _____

Other Disability: explain _____

Is this the camper's first time attending Camp New Hope? Yes No If no, did camper have any problems here: _____

Has the camper ever been separated from his or her family before? Yes No If yes, reaction and/or issues: _____

Is homesickness likely to occur? Yes No if yes, suggestions to ease the transition: _____

Does the camper attend school? Yes No Where? _____

Is the camper employed? Yes No Type of Work? _____

Will the participant stay with a group? Yes No

Best way to get participant involved: _____

Favorite Activities (camp or home): _____

Situations that may cause fearfulness or upset: _____

Mobility & Special Aides

Camper uses: (Check all that apply) Eyeglasses Helmet Hearing Aids Dentures Walker Crutches

Leg Braces Gait Belt Other Adaptive Equipment: _____

Wheelchair: Manual Electric Moves: Independently Requires Pushing Steering

Transfers: Independently Standby Assistance Pivot (1 person) Full Assistance (2 person) Hoyer Lift

Swimming needs: Ear plugs Nose plug Water shoes Lifejacket Goggles None

Toileting & Showering

- Uses Toilet Independently Needs Reminders: _____ Able to tell you when needed.
- Needs Assistance (wiping, removing or putting on pants): _____
- Has toilet schedule (explain): _____ Doesn't use toilet at all: (depends, etc) _____
- Uses catheterization or other adaptive devices: Describe: _____
- Menstrual Care: None Independent Needs Assistance: _____
- Showering: Independent Needs Verbal Cues Needs Complete Assistance: Shower Chair Shower Bed
- Needs Assistance with: Adjusting Water Temp Shampooing Hair Soaping Drying Brushing Teeth

Dressing

- Is camper responsible for own belongings Yes No
- Dresses Independently Needs minimal assistance dressing Needs total assistance dressing
- Describe assistance needed dressing: _____
- Describe any assistance needed undressing: _____

Bedtime

- Typical Bedtime: _____ Awakes at: _____ Sleeps: _____ hours a night
- Does camper need a bedrail Yes No (Campers with active, regular seizures, requires a bedrail.)
- If camper is non-verbal, how does camper typically sleep? (back, side, belly, with pillow, etc) _____
- Does camper require special care during the night? Yes No if yes, explain: _____
- Does camper wet the bed at night? Always Sometimes Never Does camper wear pull-ups to bed? Yes No

Behavior and Communications

- Any disruptive behaviors? Yes No If yes, describe: _____
- Does camper respond to specific behavior techniques? Yes No If yes, describe: _____
- Situations/Activities/Foods that can cause behavior problems? Describe: _____
- Does camper usually comply with verbal requests/directions? Yes No
- Does the participant verbalize clearly? Yes No If no, describe : _____
- Describe special Communications needs or instructions (sign language, special gestures, etc.): _____
- Is there any possibility camper's behavior would risk injuring self or others? Yes No If yes, describe: _____
- Is the camper ever violent or dangerous to others? Yes No If yes, explain: _____
- Is the camper usually willing to share/take turns? Yes No
- Does the camper tend to give up or become frustrated when confronted by challenging activities? Yes No
- Please list any information concerning camper that would aid our staff in insuring their time at camp is safe and enjoyable: _____
- _____
- _____
- _____

Meal Time

Typical Appetite is: Large Typical Small

Food Likes: _____

Food Dislikes: _____

Camper can use: Fork Spoon Knife Special Utensils, describe: _____

Camper needs: Food Cut Sippy Cup Straw Food fed to them Liquids Thickened (consistency): _____

Other special instructions: _____

Medication

Camper Name: _____

How does the camper take medication? Chews With Liquid Whole in food Crushed in food

Other: _____

If your camper has a need for over the counter medications during camp, dispensed on an as needed basis (PRN), such as: (Benadryl, Anti-Diarrheal, Constipation, Heartburn/ TUMS, Cough Drops), please bring these medicines with you as camp does not supply them to campers. Do not bring Tylenol or Ibuprofen; camp has these medications here.

The nurse has my permission to administer Tylenol or Ibuprofen to my camper, if needed. Yes No initial _____

Circle Preference: Tylenol / Ibuprofen

Medications: List Current Medications, Dosage, and place check in Time for Administering. If other, write the specific time in the box.	8am	12pm	5pm	8pm	Other	PRN
Example: Metformin 500 mg, Take 1 tab twice daily	X			X		
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
Put any additional medications on a separate sheet of paper						

By signing below, I acknowledge that the medications listed above are correct at the current date listed below and that they may be administered by the Nurse at Camp New Hope upon verification at check-in.

Signature of Responsible Person: _____ Date: _____

Allergies:

Food Allergy? Yes No

Medication Allergy? Yes No

Insect Bite/Sting Allergy? Yes No

Other Allergies? Yes No

Carries Epi-Pen? Yes No

If yes, describe in detail what the participant is allergic to and the allergic reaction.

Special Dietary Needs/Restrictions:

Describe special dietary needs and special food preparation requirements.

Seizures: Yes No Type of Seizures: _____

Frequency: _____ Last Seizure Date: _____

Aware of impending seizure? Yes No If yes, describe: _____

Describe care required during/after seizure: _____

Other Medical Conditions:

Asthma Communicable Disease Heart Condition G-tube Other Condition: _____

Diabetes. Please Describe: No Meds Check Blood Sugar Daily Oral Medication Insulin Pen Vile Insulin

Please check if camper suffers from any of the following on a frequent basis:

Headaches Migraines Constipation Diarrhea Arthritis or Joint Problems Stomach Disorders Colds Skin Problems Problems Sleeping

Please List any Activity Restrictions: _____

Medical Authorization/Permission to Treat Form for Camp New Hope, Inc. (2018)

Form must be filled out completely.

Medications

I, being the parent or guardian of (camper name) _____, do hereby authorize appointed staff of Camp New Hope to administer all medicines, prescription drugs and other medical remedies required for or on behalf of the above named person, while said person is participating in or at a Camp New Hope function.

I specifically agree to advise the staff and personnel of Camp New Hope of all prescribed and over the counter medicines which are needed for the above named person.

Permission to Treat

I hereby give permission to the medical personnel selected by the staff at Camp New Hope, 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 for above named person.

In the event of an emergency in which I cannot be reached, I hereby give permission to the Emergency Personnel or physician selected by the staff at Camp New Hope, to secure and administer treatment, including hospitalization, for the above named person.

I further waive any claim on behalf of myself and the above named person pursuant to this authorization. I further warrant that I have the authority to grant this medical authorization on behalf of the above named person. Furthermore, I agree to hold Camp New Hope harmless by reason of my execution of this medical authorization and permission to treat.

This completed form may be photocopied for trips outside of Camp New Hope.

Signed: _____ Date: _____

(Signature of camper (if own guardian) or parent/legal guardian if other than parent)