LIONS CAMP HORIZON
7506 Gemini Street
Blaine, WA 98230
360-371-0531 www.lionscamphorizon.org

# CAMPER INFORMATION

(Please print clearly)

FOR OFFICE USE ONLY: YEAR: 20____

DATE RECEIVED: _____

DEPOSIT REC'D:_____

SESSION(S) REQUESTED:_____

Applications are processed on a first come-first serve basis. Please answer *all* questions even if your camper has attended LCH in the past. Incomplete applications and applications without the $50.00 deposit will be returned. Deposits are non-refundable and session space will not be guaranteed if all required documents & payment in full are not received by June 1st unless pre-approved by the Camp Director.

Camper's Name: _____
First Middle Last

Does your camper have a nickname? _____ Date of Birth: _____ (mm/dd/yyyy)

Male_____ Female_____ Telephone No. _____ Email: _____

Camper's Address: _____ City: _____ Zip: _____

Mailing Address if different from above: _____

Parent/Guardian Name(s): _____

Home Phone: _____ Work Phone: _____Cell:_____

Name of Group Home (If applicable): _____

Group Home Manager's Name: _____ Telephone: _____

Group Home Manager's Email: _____

Who should mail be sent to? _____ Camper _____ Parent/Guardian _____Other (if other please provide

name/address/relationship to camper): _____

_____

## Emergency Contact Information (other than those listed above)

Contact #1: _____ Contact #2: _____

Relationship: _____ Relationship: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Will DSHS cover registration fees? Yes:: _____No: _____ Provide the Case Manager's name, mailing address and telephone number if we are to bill DSHS:

_____

_____

CAMPER'S NAME:_____AGE:_____

PERSONAL INFORMATION

The information you provide on the next few pages is critical in assuring your camper's needs are met and that his/her camp experience will be fun-filled and memorable. If there is anything we should know that isn't addressed in the following pages, please attach a separate sheet with your comments. Required fields are indicated in RED.

Primary Diagnosis: _____

Secondary Diagnosis: _____

Other conditions/Concerns: _____

MOBILITY

____Walks/runs independently ____Needs assistance walking/running ____Needs assistance with steps

____Uses a cane ____Uses a manual wheelchair ____Uses a motorized wheelchair

____Uses a Gait Belt ____Wears AFOs or braces on legs ____Uses a walker ____Other (list)_____

If your camper uses a wheelchair, describe transfer procedure and level of assistance required: (If not applicable, please write "N/A")

____Is camper prone to slipping and/or falling? If yes, what type of surfaces? _____
_____

ACTIVITY LEVEL

____Has typical attention span ____Has short attention span ____Easily distracted ____Is hyperactive

____Will participate in most activities ____Refuses to participate/prefers to watch ____Is underactive (needs motivation)

____Stays with group ____Wanders away from group (if camper wanders, how do you redirect his/her attention? _____
_____

ACTIVITIES

What are some favorite activities? _____

Activities your camper does NOT like:_____

We may go horseback riding, have visits from therapy animals or "guests" from a petting zoo. Is your camper:

____Afraid of animals? If yes, what kind?_____

____Allergic to animals? What kind? _____ Reaction:_____

CAMPER'S NAME:_____AGE:_____

PERSONAL INFORMATION

ACTIVITIES (CONTINUED)

_____Has good fine motor skills _____Has poor fine motor skills _____Needs hand over hand

_____Sensitive to loud noises? (if yes, what type?)_____

_____Uses earmuffs or ear plugs to block noise _____Sensitive to flashing / twinkling lights or disco ball lights

If there is additional information we need to know for activity planning, please advise in the box below:
(If not applicable, please write "N/A")

HYGIENE AND PERSONAL CARE

_____Uses the toilet on a schedule? What is the schedule? _____

_____Uses toilet independently? How do they let you know they need to go? _____

_____Needs some assistance using the toilet? Please explain:_____

_____Does not use toilet at all; uses incontinence briefs (An adequate supply of briefs must be provided for the camper)

_____Requires enemas or suppositories; describe bowel schedule: _____

_____Has a catheter; does camper change independently or is assistance needed? _____

_____Does camper have a Urostomy Bag? _____Colostomy Bag? Describe schedule: _____

For female campers:
_____ Is camper independent in menstrual care? If not, and menses will take place during camp session please advise support/assistance needed:
(If not applicable, please write "N/A")

SHOWERING

_____Can shower independently _____Needs complete assistance in the shower _____Needs assistance adjusting water

_____Prefers evening shower _____Needs assistance shampooing _____Needs assistance soaping

_____Prefers morning shower _____Needs shower chair or bench Other:_____

How often does camper shower? _____

CAMPER'S NAME:_____AGE:_____

PERSONAL INFORMATION

DRESSING

_____ Has no difficulty dressing _____Can choose own clothes _____Needs some assistance with dressing

_____Needs total assistance with dressing _____Can undress partially _____Needs total assistance undressing

_____Can tie shoes _____Can work buttons _____Can work snaps _____Can manage zippers _____Can put on belts

In the box below describe assistance needed if not addressed above: (If not applicable, please write "N/A")

SLEEP

_____Uses CPAP or VPAP _____Snores _____Light sleeper _____Heavy sleeper _____Needs night light

_____Sleep walks _____Sings/cries at night _____Needs bed checks for incontinence (if so, when?) _____

_____Should be woken to use toilet (If so, what time?) _____Wakes frequently throughout the night (If so, how do you help get your camper back to sleep?)_____

Please provide any other information that may be helpful with camper's night time routine: (If not applicable, please write "N/A")

COMMUNICATION

_____Verbal _____Uses only single words _____Uses complete sentences _____Non-verbal _____Mute

_____Comprehends 2-3 words _____Comprehends complete sentences _____Gestures / points to desired items

_____Uses vocalizations _____Uses PEC boards _____Uses sign language _____Understands sign language

_____Uses an AAC device _____Writes to communicate

Please provide any other information that may be helpful: (If not applicable, please write "N/A")

CAMPER'S NAME:_____AGE:_____

PERSONAL INFORMATION

BEHAVIORS

_____Does well in large groups (12 or more individuals) _____Does well is small groups (fewer than 12)

_____Prefers to be alone _____Is sensitive to touch _____Quick to anger (If so, please describe triggers):

_____

_____Aggressive with others. If so, please describe triggers: _____

_____

_____Does camper have a history of self abuse? If so, please advise stressors: _____

_____

_____Does camper exhibit obsessive - compulsive behaviors, or any other challenging behaviors? If yes, please explain:

_____

What are effective responses to these behaviors? _____

_____

What are effective rewards? _____

What are effective ways to re-direct the camper? _____

Please use the box below to provide additional information that will help us meet your camper's needs:
(If not applicable, please write "N/A")

CAMPER'S NAME:_____AGE:_____

PERSONAL INFORMATION

DIETARY

_____Diabetic _____Sugar free _____Lactose intolerant _____Dairy free _____Gluten free diet _____Soft diet

_____Vegetarian diet _____Liquids thickened to the following consistency: _____Nectar _____Honey _____Pudding

_____Has a good appetite _____Has a poor appetite _____Eats excessively _____Eats fast/needs supervision

_____Needs food cut up _____Need food blended _____Difficulty swallowing _____Takes portions independently

_____Uses special or over-sized utensils (please provide & label with camper's name) _____Drinks from cup unassisted

_____Needs straw _____Needs special cup (please provide & label with camper's name) _____Difficulty swallowing

_____Chokes easily _____Eats through G-Tube (partially) _____Eats through G-Tube (all food)

_____History of spitting/throwing or grabbing food _____History of binging _____History of purging

List all foods your camper cannot eat due to severe intolerance and/or allergic reactions:

_____

List any ingredients in processed or packaged foods your camper cannot eat due to intolerance and/or allergic reactions: _____

If your camper ingests or comes in contact with any foods or ingredients listed above, describe his/her reaction. Please include physical or behavioral signs/symptoms evidenced and low long after contact symptoms begin:

_____

_____

List emergency protocols recommended by your camper's physician to treat the reaction and reverse the symptoms. (For example Benadryl, Epi-pen, Syrup of Ipepac, etc.) :_____

_____

List all foods and/or ingredients in processed or packaged foods that do not cause moderate or severe allergic reactions *but* may cause physical discomfort, affect mood or behavior: _____

_____

_____

If you have any questions or concerns regarding Food Service and your camper's dietary needs, please call the Food Services Coordinator at 360-371-0531.

CAMPER'S NAME:_____AGE:_____

MEDICAL INFORMATION

Primary physician:_____ Telephone number:_____

Medical Insurance provider:_____ Policy #:_____

Medicaid number:_____

Primary Diagnosis:_____ Secondary:_____

Drug allergies:_____

Reaction(s):_____

Seasonal allergies:_____ Reaction:_____

Other allergies (such as bee stings):_____ Reaction:_____

Asthma:_____ COPD:_____

Does camper use an inhaler? _____ What type? _____Is assistance required?_____

Does camper use an Epi-Pen? _____ Is assistance required? _____ Nebulizer? _____

Does camper smoke? _____ Please note we are a non-smoking facility and accommodations cannot be made for smokers.

IMMUNIZATIONS

| TYPE | DATE | BOOSTER | BOOSTER | BOOSTER |
|---|---|---|---|---|
| DPT/Dtap (Diptheria Tetanus Pertusis) | | | | |
| Td/DT (Tetanus Diptheria) | | | | |
| OPV/IPV - Polio | | | | |
| MMR (Measles Mumps Rubella) | | | | |
| HB - Hepatitis B | | | | |
| Varicella (chicken Pox) | | | | |
| Influenza Vaccine | | | | |
| Meningitis | | | | |
| TB (Tuberculosis) | | | | |

CAMPER'S NAME:_____AGE:_____

MEDICAL INFORMATION

Does your camper have seizures? If yes, what type? _____Frequency:_____

Describe what usually happens prior, during, and after a seizure:_____

_____

Does your camper have Diabetes?_____ High blood pressure?_____ Heart problems?_____ Fainting spells?_____
TBI?_____ Back injury?_____ Chronic pain?_____ Eyeglasses?_____ Contacts?_____ Hearing Aids?_____

CURRENT MEDICATIONS
Please list all prescription medications and over-the-counter medications. Include dosages and frequency:

_____
_____
_____
_____
_____

TO PARENT/GUARDIAN
All campers are required to have a physical examination by his/her Physician, Nurse Practitioner or Physician's Assistant within the six (6) months prior to the start of camp. The Physical Exam Form consists of two (2) pages and must be received by Lions Camp Horizon no later than June 1st. Be sure to make appointments early so you are able to make the deadline. Campers will not be allowed to attend camp without the Physical Exam Form in file.

All medications brought to camp must be in blister packs. If blister packs are not available, medications must be in the original containers with the dispensing instructions, date of prescription, and prescribing physician clearly visible on the pharmacy label.

We stock most over-the-counter medications (such as Tylenol, Ibuprofen, Benadryl, Pepto Bismol.) Please check with us in advance to see if we have a specific OTC medication your camper may need.

We cannot refill prescriptions. You must provide sufficient quantities of prescription medications for five (5) days.

Please include a photocopy of your camper's current medical insurance card or a copy of his/her current medical coupon with this camper application.

Parent/Guardian Consent:
I hereby give permission to Lions Camp Horizon medical staff to provide routine health care and first aid; to administer the prescription medications and/or over-the-counter medications that the camper's licensed healthcare provider listed on the Physical Examination Form; to release any records necessary for insurance purposes; and to provide or arrange transportation to access medical care deemed necessary for my camper. _____ Parent/Guardian Initial

In the event I cannot be reached in an emergency, I hereby give permission to the health care provider selected by the LCH staff to administer treatment including x-rays, routine tests, injections, surgery, or hospitalization for _____ (camper's name) _____ Parent/Guardian Initial

I hereby release and waive claim, cause, or action which may accrue against LCH, any employee thereof, or any other persons acting with their permission, for any injury that may happen to the camper during his/her stay at LCH or during an activity approved by any of the said persons. _____ Parent/Guardian Initial

Parent/Guardian Signature_____ Date_____

# LIONS CAMP HORIZON
## PHYSICAL EXAMINATION FORM

THIS FORM MUST BE RECEIVED NO LATER THAN JUNE 1st

PART I: Personal Information (to be completed by parent/guardian)

Camper's Name: _____ Nickname:_____ DOB:_____
_____ Male _____ Female Custodial Parent/Guardian:_____
Address: _____
Street City State Zip
Telephone: _____ Email Address: _____

PART II Medical Information (to be completed by healthcare provider)
Height:_____ Weight:_____ Blood Pressure:_____ Heart Rate:_____ Respiration:_____ Temp:_____

Assessment:
Skin/scalp: _____ Eyes: _____ Ears: _____ Nose, throat, & mouth: _____ Glands: _____
Teeth & gums: _____ Lungs: _____ Heart: _____ Abdomen: _____
Allergies:
Medications: _____
Insect stings:_____ Does camper have a prescription for an Epi-Pen? _____
Environmental: _____ Other: _____
Does camper have a prescription for a rescue inhaler? Yes _____ No _____
Does camper have a history of seizures? Yes _____ No _____ Date of last seizure:_____ If yes, please advise what type and frequency: _____
_____
Does camper require a portable oxygen tank?_____ CPAP or VPAP:_____
Does camper require a mouth guard during sleep?_____

Vaccinations:
Date of last Tetanus vaccine: _____ Date of last TB test: _____ Positive: _____ Negative: _____ PPB reactor: _____
Individual is current on all vaccinations except: _____

Current or chronic medical conditions: _____
_____
_____
_____
Medically prescribed dietary restrictions or meal plan: _____
_____
_____
_____
Camp activities include nature walks, outdoor games and activities, arts & crafts and bowling. Please advise any restrictions on physical activities at camp: _____
_____
_____
Additional information for our nursing staff: _____
_____
_____
_____
_____

# LIONS CAMP HORIZON
## PHYSICAL EXAMINATION FORM

### MEDICATIONS

No prescription medications or over-the-counter medications will be dispensed to the camper without the signature of a licensed healthcare provider. Please provide a complete list of the medications prescribed for this camper including herbal remedies in the box below. Unless medically necessary to do otherwise, medications are administered at the following times: 8AM (breakfast), Noon (lunch), 5PM (dinner), and 8PM. Please write exceptions to this under "Comments."

### PRESCRIPTION MEDICATIONS

| Medication | Dosage | Comments |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

### OVER - THE - COUNTER MEDICATIONS

I authorize the use of the following OTC medications to be used for their intended purposes on a PRN (as needed) basis for a maximum of two consecutive days. A check has been placed before each of the medications that may be administered.

_____ Acetaminophen 325mg 1-2 tabs or liquid equivalent, for headache, pain, menstrual cramps or fever >100.5
_____ Ibuprofen, 200mg 1-2 tabs, or liquid equivalent, for headache, pain, or menstrual cramps or fever >100.5
_____ Diphenhydramine 25mg, 1-2 tabs, or liquid equivalent for itching, rash or allergic reaction
_____ Non-narcotic cough suppressant/expectorant 2 tsp (10cc) for cough _____ Sugar free only
_____ Cough drops 1 lozenge, for sore throat (up to 10 drops per day)
_____ Pseudoephedrine HCL 30mg 2 tabs, for nasal congestion due to colds or sinusitis
_____ Alum/Magnesium Hydroxide liquid w/ simethacone 2 tbsp (30cc)
_____ Pepto Bismol 2 tbsp (30cc) _____ Simethicone 1-2 tabs after meals for gas (not to exceed 4 tabs per day)
_____ Milk of Magnesia 2 tbsp (30cc) followed by 8 ounces of water for constipation
_____ Kaopectate 2 tbsp (30cc) for diarrhea. One dose after each loose bowel movement for a maximum of 8 tbsp/24 hours
_____ Loperamide HCL liquid 4 tsps (20cc) for first loose bowel movement and 2 tsps (10cc) after each other loose bowel movements for a maximum of 8 tsps (40cc) in a 24 hour period
_____ Visine eye drops or similar product 1-2 drops per eye for red, itchy eyes
_____ Bacitracin for minor abrasions _____ Triple Antibiotic Cream for minor abrasions
_____ Hydrogen Peroxide full strength for cleaning minor cuts and abrasions of the skin
_____ Betadine Solution full strength for wound disinfection, abrasions, emergency lacerations
_____ Dermoplast (spray) TID, for relief of minor burn discomfort _____ Blistex or _____ Vaseline for chapped lips
_____ Sunscreen SPF 30 or higher and/or _____ Insect Repellant (neither subjected to the two day limit)

Signature of licensed practitioner completing Health Exam Form: _____

Printed name: _____ Date: _____

Telephone number: _____