

Camp Hope: All About Me

Camper Health Information

YEAR: _____

PLEASE COMPLETE AND RETURN TO:

Camp Magruder
17450 Old Pacific Hwy
Rockaway Beach, OR 97136

PLEASE NOTE: Completely fill out, sign and date where requested. This information must be completed and returned no later than June 14, 2022, to finalize your registration.

GENERAL INFORMATION:

Camper Last Name: _____ First: _____

Nickname: _____

Home Address: _____ PO Box/Apt #: _____

City: _____ State: _____ Zip Code: _____

Male Female

Date of Birth: _____ What will be the camper's age be at camp? _____

(Must be 18 Years old by the start of camp)

Please Check One

Lives Independently

Lives with Care Provider

Provider Name: _____

Phone: () _____

Guardian:

Name: _____ Home Phone:() _____

Work Phone:() _____ Cell:() _____

Mailing Address: _____ PO Box/Apt #: _____

City: _____ State: _____ Zip Code: _____

Is the Guardian a:

Legal Parent?

Foster Parent?

Does the camper have a caseworker? Yes No

Caseworker's Name: _____

Phone:(____) _____

INSURANCE INFORMATION:

Name of Insured: _____

Carrier: _____ Group #: _____ Policy #: _____

CAMPER'S PERSONAL INFORMATION:

Camper's Height _____ Camper's Weight _____

Functioning Age/Grade Level _____

T-Shirt Size (in men's sizes, please circle): S M L XL XXL XXXL

School/Work Station (Name of Program): _____

Diagnosis Information:

What is the Camper's diagnosis or special need(s)?

(Please check all that apply)

Autism Developmental Delay Down Syndrome Cerebral Palsy Mentally Disabled

Other _____

(Using the space below, please describe fully)

Secondary Disabilities: *(Please explain and describe)*

-Visual _____ -Physical _____

-Hearing _____ -Medical _____

-Emotional _____ -Epilepsy _____

-Behavior _____ -Cognitive _____

-Other _____

Explanation for above- *(if needed)*

APPLIANCES:

Please check appliances used by camper and circle the times worn, if applicable:

- Leg Braces:** Day Night
- Single Double Short Long

- Prosthesis:** Day Night
- Arm Leg Eye Other
- Right Left Both

- Hand Spacers Day Night
- Corset Day Night
- Hosiery/Stockings Day Night
- Crutches
- Cane
- Walker
- Special Shoes
- Glasses
- Arch Supports/Inserts
- Wheelchair

_____ Other (*Specify*)_____

Explanation for above- (*if needed*):_____

Current Medication(s):

PLEASE NOTE: When bringing medication (over the counter and/or prescription) that need to be taken routinely, it is required that it is all kept in its original container that identifies the name of the drug, dosage, and prescribing physician.

NAME	DOSAGE	WHEN TAKEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If extra medication room is needed, please add to back of form)

MEDICAL CONDITIONS

If any of the following conditions apply, please describe fully.

Allergies:

Food Allergies: _____

Drugs Allergies: _____

Other Allergies (including hay fever, asthma, insect stings, animal dander, etc): _____

Hepatitis Carrier- _____

Asthma- _____

Communicable Diseases- _____

Arthritis- _____

Obesity- _____

Seizures? Yes No

When was the last seizure? _____

How often do they occur? _____

~PLEASE ATTACH SEIZURE PLAN~

Does/ has the camper:

- | | |
|---|--|
| 1. Had a recent injury, illness, or infectious disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have a chronic or recurring illness? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have frequent headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Ever had frequent ear infections? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Ever had problems with exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Ever had blood pressure problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Ever had joint or back problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Have any skin problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Ever had an eating disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Required psychiatric treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Bowel issues? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Bladder Issues? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. A catheter? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. A bedwetting problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Other issues? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please elaborate on all "Yes" answers, noting the **number of the questions:** _____

(If more room is needed, attach to last page)

COVID 19 PROTOCOLS:

Has the camper been vaccinated against Covid 19? Yes No
How many doses? _____ Date of most recent booster shot: _____

Is the camper able to wear a face mask while indoors? _____
Is the camper able to wear a face mask for an extended period of time? _____
Is there anything you would like us to know about the camper regarding Covid protocols?

OTHER NEEDS:

Will the Camper need reminding or help with:

_____ Eating (*cutting food, feeding, etc.*)- _____

_____ Toileting- _____

_____ Showering (*shampooing, temperature, etc.*) _____

_____ Tooth brushing & Grooming (*shaving, hair brushing, applying deodorant, etc.*)- _____

_____ Dressing- _____

_____ Assistive Devices- _____

MEALS:

Is the camper a big eater? Yes No

Describe a typical- Breakfast: _____

 Lunch: _____

 Dinner: _____

Does the camper drink-
Milk? _____ Tea? _____ Hot Chocolate? _____ Decaf Coffee? _____ Caffeinated Coffee?

COMMUNICATION:

Expressive:

Camper expresses him/herself through:

Verbal:

- Single Words
- Phrases
- Conversation

Non-verbal:

- Facial Gestures
- Hand Gestures
- Body Gestures
- Sign Language
 - MCE, Manual Coded English
 - ASL, American Sign **Language**

Camper can express: Wants/Needs Thoughts/Feelings/Beliefs

Other:(Such as feelings and/or beliefs camper feels strongly about, etc.)_____

Receptive:

Camper understands and is most comfortable with:

Verbal Instructions:

- Few Words
- One-Step Instructions
- Two-Step Instructions
- Multi-Step Instructions
- Conversational

Does the camper understand:

- Sign Language
 - MCE, Manual Coded English
 - ASL, American Sign Language

CAMPER SAFETY & ADDITIONAL INFORMATION:

_____ Does the camper need constant supervision?

_____ Does the camper play with dangerous objects?

_____ Does the camper have safety skills with scissors?

_____ Can the camper navigate stairs safely?

_____ Is the camper a smoker?

_____ Has the camper been away from home overnight before?

_____ Has the camper ever been homesick?

_____ Is the camper physically aggressive when angry? Please explain: _____

_____ Is it safe for the camper to be around children? If not, please explain: _____

Please describe the camper's sleep pattern: _____

If the camper is upset, what calms them? _____

Are there any particular things that upset the camper? _____

CAMP ACTIVITIES

All camp activities are revised in accordance to the camper's abilities, and all are closely supervised. Please indicate the activities in which the camper will feel comfortable to participate?

- Walks
- Hikes
- Swimming
- Boating
- Strenuous activity

Please use space provided below for any additional comments, details, and/or information that have not been addressed.

Dear Camper,

Please write a brief paragraph about yourself, or have someone write it for you. Tell about your family and list your hobbies, skills, recreation, likes and dislikes, and anything else to enable the staff to know you better.

“About me” _____

OPTIONAL: Send a picture of the camper with this completed information sheet. Please label photo with applicant’s full name and date photo was taken.

I, the guardian or caretaker of _____ give my permission to the camp health care provider of his/her designate to give the follow medications (or their generic equivalents) to the registrant in accordance with recommended package dosing for the specific indications below. These medications are available at camps and need not be brought by partipants.

Tylenol: *Mild fever or discomforts* Yes No
Ibuprofen: *Mild fever or discomforts* Yes No
Throat Lozenges: *Cough/sore throat* Yes No

Topical Creams: *Itching, sunburn, or insect bites* Yes No
Benadryl: *Allergy symptoms* Yes No
Antacid: *Upset stomach* Yes No
Anti-diarrheal: *For diarrhea* Yes No

Permission to follow recommendations by Oregon Poison Control or Idaho Poison Control. Yes No

This form has been completed by:

Signature of guardian/caretaker: _____

Printed Name: _____

Relationship to camper: _____ Date signed: _____

Camper’s signature: _____ Date signed: _____

Parent/Guardian signature: _____ Date signed: _____

Camper's Name _____ Birthdate _____

Gender Male Female

Height (Feet and Inches): _____ Weight (Lbs): _____

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE:

The above-named camper has permission to take part in all camp activities under supervision unless limitations are noted above, and I agree that the camp or camp personnel will not be held responsible for accidents arising therefrom. I hereby give permission to the camp to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. In the event that I or the emergency contact cannot be reached in an emergency, I hereby give permission to the medical personnel selected by the camp to secure and administer treatment, including hospitalization, and to provide or arrange necessary related transportation for the person named above. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the camper. I agree to the release of any records necessary for insurance purposes. A printed version of this completed health form may be photocopied for trips out of camp.

Your signature below confirms that you have read the medical waiver, that you understand it, and that you agree to be bound by it. If you do not agree to this waiver, the above-named camper will not be able to attend camp.

Parent/Guardian Full Name: _____

Signature: _____

Date: _____

SOCIAL MEDIA POLICY

I confirm I have read and understand the Social Media Policy of Camp and Retreat Ministries of the Oregon-Idaho Conference. For more details:

<https://www.gocamping.org/readyssetgotocamp>.

If you do not sign, the camper will not be able to attend camp.

Your Full Name: _____

Signature: _____

Date: _____

PHOTO RELEASE

I give permission for the above-named camper's photo, oral interview or written material to be used in advertising of the camp or camping program. For more details:

<https://www.gocamping.org/readyssetgotocamp>

Yes No

Your Full Name: _____

Signature: _____

Date: _____