



North Carolina & Virginia

# Super Summer Camp Application

**ALL FORMS MUST BE COMPLETELY FILLED OUT. PLEASE PRINT.**

2016 Summer Application – New Castle, VA

## Camper Information

Full Name \_\_\_\_\_ Nickname \_\_\_\_\_

Birth date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender  Female  Male

Ethnicity \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone # \_\_\_\_\_

Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Email camp updates to \_\_\_\_\_ T-shirt Size \_\_\_\_\_

Do you have a family member in the military?  Yes  No Relation to camper \_\_\_\_\_ Branch \_\_\_\_\_

Do you have a disability?  Yes  No If so, check all that apply

- |   |  |
|---|--|
| <input type="radio"/> Asperger's Syndrome                       | <input type="radio"/> Heart, Circulatory, Respiratory Defect   |
| <input type="radio"/> Asthma                                    | <input type="radio"/> Intellectual Disabilities  |
| <input type="radio"/> Attention Deficit Disorder/ADHD           | <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe/Profound |
| <input type="radio"/> Autism                                    | <input type="radio"/> Learning Disability  |
| <input type="radio"/> Behavior Disorder                         | <input type="radio"/> Muscular Dystrophy   |
| <input type="radio"/> Bleeding/Clotting Disorder                | <input type="radio"/> Psychosis  |
| <input type="radio"/> Cerebral Palsy                            | <input type="radio"/> Speech-Language/Voice Dysfunction  |
| <input type="radio"/> Cystic Fibrosis                           | <input type="radio"/> Spina Bifida   |
| <input type="radio"/> Diabetes                                  | <input type="radio"/> Spinal Cord Injury   |
| <input type="radio"/> Developmental Disorder                    | <input type="checkbox"/> Quadriplegic <input type="checkbox"/> Paraplegic <input type="checkbox"/> Other |
| <input type="radio"/> Down Syndrome                             | <input type="radio"/> Social/Psychological   |
| <input type="radio"/> Epilepsy/Seizure Disorder                 | <input type="radio"/> Visual Impairment  |
| <input type="radio"/> Fragile X                                 | <input type="checkbox"/> Partial <input type="checkbox"/> Total  |
| <input type="radio"/> Hearing Impaired                          | <input type="radio"/> Other Disability(s) _____  |
| <input type="checkbox"/> Partial <input type="checkbox"/> Total |  |

## Parent/Caregiver Information

Custodial Parent/Guardian \_\_\_\_\_

Relation to camper \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Street Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

2<sup>nd</sup> Custodial Parent/Guardian \_\_\_\_\_ Relation to camper \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Street Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Alternative Emergency Contact \_\_\_\_\_ Relation to camper \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

## Referral Information

Has the camper attended Camp Easter Seals UCP before?  Yes  No

If yes, please list the years the camper has attended: \_\_\_\_\_

If no, please indicate how the camper found out about Camp Easter Seals UCP: \_\_\_\_\_

**Camper's Care Information**

**Mobility**

- Walks  Uses walker
- Uses wheelchair, can propel/drive self?  Yes  No

**Transfers**  No assists needed  Needs assistance (explain): \_\_\_\_\_

**Assistive Devices**  None  AFO's  Glasses  Hearing aid  Helmet  Other \_\_\_\_\_

**Communication**  No serious difficulties expressing thoughts or wants  Has difficulties (explain): \_\_\_\_\_

Uses sign language  Uses a communication device (what kind?): \_\_\_\_\_

**Eating**  No assistance needed  Needs assistance (explain): \_\_\_\_\_

**Diet**  Normal  Blended/Pureed  Diabetic  Food allergies (list): \_\_\_\_\_

Special – please attach a list of special diet so we can determine if we can meet your needs

**Bowel Control**  No assistance needed  Incontinent  Needs assistance/schedule (explain): \_\_\_\_\_

**Bladder Control**  No assistance needed  Incontinent  Needs assistance/schedule (explain): \_\_\_\_\_

**Aids Used**  None  Catheter  Urinal  Disposable undergarments  Other \_\_\_\_\_

**Dressing**  No assistance needed  Assistance needed (describe): \_\_\_\_\_

**Washing/showering**  No assistance needed  Some assistance needed (describe): \_\_\_\_\_

Total assistance needed (describe): \_\_\_\_\_

**Sleeping**  Typical sleeping habits  Has trouble going to sleep  Has nightmares  Sleep walks

Special bedtime routines: \_\_\_\_\_

Usual bedtime: \_\_\_\_\_ Usual wake up time: \_\_\_\_\_

*Individuals 16 and older may sleep on the upper bunk with person with parent or guardian's permission.*

To give your camper permission to use the upper bunk, please initial here: \_\_\_\_\_

**Camper's Social Background**

School/employer \_\_\_\_\_ Grade level \_\_\_\_\_

Can the camper read?  Yes  No Write?  Yes  No

Does the camper have any special behavior problems?  Yes  No If yes, please describe \_\_\_\_\_

When do behavior problems occur? \_\_\_\_\_

Describe effective methods to control difficult behaviors: \_\_\_\_\_

Please list any fears the camper may have: \_\_\_\_\_

Please list any activities the camper dislikes: \_\_\_\_\_

What hobbies or activities does the camper enjoy at home or school? \_\_\_\_\_

Please add any other information you feel would be helpful in providing the best experience for the camper while at camp: \_\_\_\_\_

**Camper's Health Information**

**Medications** Please list any medications the camper uses: \_\_\_\_\_

**Seizures**  Yes  No Type \_\_\_\_\_ Frequency \_\_\_\_\_

Describe any warning signs (aura) before seizures: \_\_\_\_\_

\*\*If camper is prescribed seizure medication they **MUST** bring the medication to camp.

**Allergies**  None  Hay fever  Poison Ivy  Insect stings  Asthma  Penicillin  
 Other \_\_\_\_\_ Describe allergic reactions: \_\_\_\_\_

**Summary** Please summarize camper's medical history: \_\_\_\_\_

**Psychiatric treatment / counseling** Has the camper ever required any psychiatric treatment/counseling or hospitalizations?  Yes  No Please summarize (including dates): \_\_\_\_\_

**Shunt** Does the camper have a shunt?  Yes  No List special instructions/limitations: \_\_\_\_\_

**Feminine needs** Does the camper menstruate?  Yes  No Special treatments for cramps? \_\_\_\_\_  
List feminine products used and if they need assistance: \_\_\_\_\_

**Participation** Please list any activities the camper may NOT participate in or attach precautions or special instructions for routine camp activities: \_\_\_\_\_



**Insurance Information**

Is the camper covered by hospitalization insurance?  Yes  No

Carrier: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

*A copy of the camper's insurance/Medicaid/Medicare card or Military ID card must accompany this application. Please supply a copy of **BOTH** the **FRONT** and **BACK** of the card.*

**Place copy of FRONT of Insurance Card here.**

**Place copy of BACK of Insurance Card here.**

**Waiver & Release**

**The following section must be signed in ink by the adult camper/applicant or legal guarding of the juvenile camper/applicant before the application can be processed:**

(1) **Approval, Waiver, and Activity Consent** This application has my approval. While Easter Seals UCP North Carolina & Virginia (ESUCP) will take every reasonable precaution, it is agreed that ESUCP is not legally responsible for any accidents, incidents or injuries that may occur during the camp session, assumes no responsibility for applicant's personal property and is released from liability for any accident, incident or injury except as may be covered by camper's insurance. Applicant has my permission to engage in all camp activities, including transportation as deemed necessary, except as noted by myself or physician.

(2) **Medical Treatment** - The undersigned hereby authorizes and grants permission to any licensed/certified medical professional designated by ESUCP to provide routine medical care and administer medications or to perform any emergency procedures on the camper that would be jeopardized by any delay in providing such treatment or performing such procedures.

(3) **Permission to Provide Transportation** – I hereby grant permission for ESUCP contractors and representatives to provide transportation for the camper to seek medical attention, and agree to hold ESUCP harmless for any accident/injury that results from the provision of transportation.

(4) **Media Release** - I, the undersigned, in partial recognition of services rendered and benefits conferred by ESUCP hereby authorizes ESUCP, its employees, agents, and assigns, to release any pictures, or photographs taken of the above-named client for publication for purposes of conveying information concerning the named individual and/or ESUCP. The undersigned hereby agrees also to hold ESUCP harmless of liability should such pictures or photographs, either accompanied or unaccompanied by printed material, appear in other publications by whomsoever published, circulated, or distributed.

I understand that these materials may be published on ESUCP's network of Web sites and this may disclose my personal and protected health information online. However, ESUCP online disclosure of name and residence will be limited to first names and Camp ESUCP's location.

I understand that this authorization for media release is subject to revocation at any time, except to the extent that the media has been utilized.

I also understand and agree that this authorization for media release will terminate only upon the execution of my written statement on another sheet of paper indicating my intent to revoke this authorization. This can be stapled to your application.

**I ATTEST THAT ALL INFORMATION PROVIDED IN THESE APPLICATION MATERIALS INCLUDING THE APPLICATION, MEDICAL EXAMINATION SUMMARY, AND ANY SUPPLEMENTAL ITEMS ATTACHED ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

Legal Guardian/Adult Camper: \_\_\_\_\_ Date: \_\_\_\_\_

*Signature*

Print Name: \_\_\_\_\_

**Place Camper Photo  
here**

**Non-discrimination Statement:** In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.