



## Super Summer Camp

### 2009 CAMP APPLICATION

#### CAMPER INFORMATION

Last name:		First:		Nickname:	
Social Security #:		Birth date:		Ethnicity:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Street address:					
City:		State:		Zip:	
Phone:		E-Mail:			
Do you have a family member in the military? <input type="checkbox"/> Y <input type="checkbox"/> N			Relation to child:		Branch of Military:

#### Parent/Guardian (place check mark next to address to which acceptance information should be sent)

Custodial Parent/Guardian:		Cell Phone:	Home Phone:	Work Phone:	
<input type="checkbox"/> Street address:		City:	State:	Zip Code:	

Second Custodial Parent/Guardian:		Cell Phone:	Home Phone:	Work Phone:	
<input type="checkbox"/> Street address:		City:	State:	Zip Code:	

#### Alternative Emergency Contacts (other than parent/guardian listed above)

Name:	Relationship to Camper:		Phone:
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**NATURE OF DISABILITY**

Does the applicant have a disability  Yes  No If so, please check all that apply

<input type="checkbox"/> Speech-Language/Voice Dysfunction <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Partial <input type="checkbox"/> Total <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Partial <input type="checkbox"/> Total <input type="checkbox"/> Peripheral Nerve Injury/Disorder <input type="checkbox"/> Central Nervous System Injury/Disorder <input type="checkbox"/> Epilepsy/Seizure Disorder <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Quadriplegic <input type="checkbox"/> Paraplegic <input type="checkbox"/> Other <input type="checkbox"/> Bleeding/Clotting disorders	<input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Social/Psychological <input type="checkbox"/> Autism <input type="checkbox"/> Asperger's Syndrome <input type="checkbox"/> Behavior Disorders <input type="checkbox"/> Psychosis <input type="checkbox"/> Learning/Developmental Delay <input type="checkbox"/> Mental Retardation Level: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> Severe/profound <input type="checkbox"/> Genetic/Chromosomal <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Other: _____ <input type="checkbox"/> Fragile X _____ <input type="checkbox"/> Rhett Syndrome	<input type="checkbox"/> Attention Deficit Disorder/ADHD <input type="checkbox"/> Orthopedic Impairment(s) at Birth <input type="checkbox"/> Postural Disorders <input type="checkbox"/> Heart, Circulatory, Respiratory Defect <input type="checkbox"/> Asthma <input type="checkbox"/> Skin and Cellular Tissue Disorder <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Allergic/Metabolic/Nutritional Diseases <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Diabetes <input type="checkbox"/> Other Disabilities (please list): _____ _____ _____ _____
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**GENERAL BACKGROUND**

<b>Mobility</b>	<input type="checkbox"/> Walks independently <input type="checkbox"/> Uses Crutches <input type="checkbox"/> Uses Walker <input type="checkbox"/> Uses wheelchair (manual): can camper push self? Yes No <input type="checkbox"/> Uses wheelchair (power)
<b>Transfers</b>	<input type="checkbox"/> No assists needed <input type="checkbox"/> Can camper bear weight when standing? Yes No <input type="checkbox"/> Needs assistance (explain transfer): _____ _____ _____
<b>Assistive Devices</b>	<input type="checkbox"/> None <input type="checkbox"/> Helmet <input type="checkbox"/> AFO's <input type="checkbox"/> Prosthesis <input type="checkbox"/> Oxygen Machine <input type="checkbox"/> Glasses <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Other: _____
<b>Communication</b>	Does camper have difficulties expressing thoughts or wants? Yes No Please explain: _____ _____  Does camper use the following devices? <input type="checkbox"/> Facilitated Communication <input type="checkbox"/> Communication board <input type="checkbox"/> Sign language <input type="checkbox"/> System of gestures (please describe): _____ _____

**Personal Care**

<b>Eating</b>	Eating assistance: <input type="checkbox"/> No assistance needed <input type="checkbox"/> Partial assistance needed <input type="checkbox"/> Total assistance needed <input type="checkbox"/> Special utensils <input type="checkbox"/> G-tube <input type="checkbox"/> Please provide details: _____  Diet: <input type="checkbox"/> Normal <input type="checkbox"/> Chopped food <input type="checkbox"/> Blended/pureed <input type="checkbox"/> Low calorie <input type="checkbox"/> Low salt <input type="checkbox"/> Diabetic <input type="checkbox"/> Special diet *Attach list of special diet so we may determine if we can meet applicant's needs. <input type="checkbox"/> Food allergies(list): _____
<b>Bowel Control</b>	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Needs reminders <input type="checkbox"/> Incontinent <input type="checkbox"/> Needs assistance <input type="checkbox"/> On a schedule: if yes please describe: _____
<b>Bladder Control</b>	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Needs reminders <input type="checkbox"/> Incontinent <input type="checkbox"/> Needs assistance <input type="checkbox"/> On a schedule: if yes please describe: _____
<b>Aids Used (please be sure to bring to camp)</b>	<input type="checkbox"/> Catheter-indwelling <input type="checkbox"/> Catheter-intermittent <input type="checkbox"/> Catheter-condom <input type="checkbox"/> Urinal <input type="checkbox"/> Special toileting chair <input type="checkbox"/> Bedpan <input type="checkbox"/> Urostomy <input type="checkbox"/> Colostomy <input type="checkbox"/> Illiostomy <input type="checkbox"/> Laxatives <input type="checkbox"/> Suppositories <input type="checkbox"/> Enema <input type="checkbox"/> Disposable undergarments (when worn: _____)
<b>Dressing</b>	<input type="checkbox"/> No assistance needed <input type="checkbox"/> Partial assistance <input type="checkbox"/> Total assistance <input type="checkbox"/> Needs help with: <input type="checkbox"/> Belts <input type="checkbox"/> Zippers <input type="checkbox"/> Buttons/snaps <input type="checkbox"/> Tying shoes
<b>Washing/bathing/showering</b>	<input type="checkbox"/> No assistance needed <input type="checkbox"/> Assistance needed – tooth brushing <input type="checkbox"/> Assistance needed - shaving <input type="checkbox"/> Partial assist: please describe _____ <input type="checkbox"/> Total assist: please describe _____
<b>Sleeping</b>	Does camper have trouble going to sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No    Nightmares? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sleep walk

Turned at night: list times: \_\_\_\_\_  
 Special bedtime routines \_\_\_\_\_  
 Has camper ever slept outdoors overnight?  yes  No Describe: \_\_\_\_\_  
**Individuals 16 and older may sleep on the upper bunk.**  
 If you give permission for your camper to use the upper bunk, please initial here \_\_\_\_\_  
 Usual bedtime: \_\_\_\_\_ Usual wake up time: \_\_\_\_\_

### HEALTH INFORMATION AND RESTRICTIONS

Please list any medications applicant uses: \_\_\_\_\_  
 \_\_\_\_\_

Seizures:  Yes  No Type \_\_\_\_\_ Frequency \_\_\_\_\_  
 Describe any warning signs (aura) before seizures \_\_\_\_\_  
 \_\_\_\_\_

Allergies:  None  Hay Fever  Poison Ivy  Insect Stings  
 Asthma  Penicillin  Other: \_\_\_\_\_  
 Describe allergic reactions \_\_\_\_\_  
 \_\_\_\_\_

Please summarize applicant's medical history: \_\_\_\_\_  
 \_\_\_\_\_

Has applicant ever required any psychiatric treatment/counseling or hospitalizations?  Yes  No  
 Please summarize (include dates): \_\_\_\_\_  
 \_\_\_\_\_

Does applicant have a shunt?  Yes  No List special instructions: \_\_\_\_\_

Does applicant menstruate?  Yes  No Special treatment for cramps? \_\_\_\_\_  
 List feminine products used: \_\_\_\_\_ Do they need assistance with products:  Yes  No

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

### SOCIAL BACKGROUND

School: \_\_\_\_\_ Grade Level: \_\_\_\_\_

Can applicant read?  Yes  No Can applicant write?  Yes  No

Does applicant 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 applicant may have: \_\_\_\_\_  
 Please list any activities the applicant dislikes: \_\_\_\_\_

What hobbies or activities does the applicant enjoy at home or school: \_\_\_\_\_

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

**REFERRAL INFORMATION**

Has the applicant attended Camp Easter Seals before:  Yes  No

If Yes: List what years the applicant has attended Camp Easter Seals:

If No: Please indicate how applicant heard about Camp Easter Seals:

<input type="checkbox"/> Family Member	<input type="checkbox"/> Other camper:	<input type="checkbox"/> School (name):
<input type="checkbox"/> Website (name):	<input type="checkbox"/> Social Service Agency (name):	<input type="checkbox"/> Other (name):

**INSURANCE**

Is the applicant covered by hospitalization insurance?  Yes  No

Carrier: \_\_\_\_\_ Policy or Group Number: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_

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

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

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

**WAIVER AND RELEASE**

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

(1) This application has my approval. While Easter Seals Virginia will take every reasonable precaution, it is agreed that Easter Seals Virginia 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) The undersigned hereby authorizes and grants permission to any licensed/certified medical professional designated by Easter Seals Virginia 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) I attest that all information provided in these application materials including the application, medical examination summary, payment form and any supplemental items attached are true and correct to the best of my knowledge.

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

**No camper will be discriminated against because of race, national origin, sex, age, religion or disability**