



# 2012 CAMPER APPLICATION

## Camp Virginia Jaycee

Mailing Address: P.O. Box 648

Blue Ridge, Virginia 24064

Physical Address: 328 Bethel Road

Fincastle, Virginia

Office Phone: (540) 947 - 2972

### FOR OFFICE USE ONLY

Deposit Rec'd \_\_\_\_\_

Amt. Rec'd \_\$ \_\_\_\_\_

Check # \_\_\_\_\_

Date Approved: \_\_\_\_\_

### GENERAL INFORMATION

To prepare for each camper and to offer a quality experience during their stay, our staff depends on information in the application to become acquainted with the camper and to ensure a positive experience. Please complete with as much detail as possible, as each year we have some new counselors and volunteer staff. The information must be available to Camp Virginia Jaycee three (3) weeks prior to the camper's attendance.

### SECTION 1: CONTACT INFORMATION

Camper Name: \_\_\_\_\_ Return Camper  Yes  No  
Last First Initial Preferred Name or Nickname

Address: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email Address: \_\_\_\_\_

SSN (Last Four Digits) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female  
Mm/dd/yyyy

T-Shirt Size: (check one)  Small  Medium  Large  X-Large  XX-Large  XXX-Large

Parent or Guardian \_\_\_\_\_

Home Phone \_\_\_\_\_ Work (or Daytime) Phone \_\_\_\_\_ Cell: \_\_\_\_\_

Primary E-mail address \_\_\_\_\_ Secondary e-mail \_\_\_\_\_

Emergency Contact: Primary contact in case parent or guardian cannot be reached in an emergency:

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

### SECTION 2: GETTING TO KNOW YOU (Please be as detailed as possible)

Medical Diagnosis of Qualifying Disability: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_

When was the onset of the disability? (year and cause, if known): \_\_\_\_\_

Does camper live in Group Home?  Yes  No If so, Group Home Name \_\_\_\_\_

Point of Contact: \_\_\_\_\_ Position: \_\_\_\_\_ Phone: \_\_\_\_\_

Resident Camp Schedule	Respite Weekend Schedule
<input type="checkbox"/> Camper Week 1 = June 24 - 29 <input type="checkbox"/> Camper Week 2 = July 1 - 6 <input type="checkbox"/> Camper Week 3 = July 8 - 13 <input type="checkbox"/> Camper Week 4 = July 15 - 20 <input type="checkbox"/> Camper Week 5 = July 22 - 27 <input type="checkbox"/> Camper Week 6 = July 29 - August 3 Please number camp sessions in order of preference (1, 2, 3 ...)	<b>Weekend Not Available June 22 - 24</b> <input type="checkbox"/> Respite Weekend 1 = June 29 - July 1 <input type="checkbox"/> Respite Weekend 2 = July 6 - 8 <input type="checkbox"/> Respite Weekend 3 = July 13 - 15 <input type="checkbox"/> Respite Weekend 4 = July 20 - 22 <input type="checkbox"/> Respite Weekend 5 = July 27 - 29 Please number respite sessions in order of preference (1, 2, 3 ...)

Currently, Camp Virginia Jaycee does not provide awake overnight staff. Staff members sleep in each cabin nightly and are responsible for routine bathroom trips and assistance. We cannot accommodate campers who require consistent and frequent assistance throughout the night.

**GENERAL PHYSICAL INFORMATION:** (check all that apply)

Height: \_\_\_\_\_, Weight: \_\_\_\_\_

- Easily dehydrates  Easily constipated  Frequent loose bowels/stool  Uses inhaler  Diabetic
- Uses insulin pump  Bi-polar  Medications for anxiety  Medications for depression
- Seizures and type of seizure: \_\_\_\_\_ Frequency \_\_\_\_\_ Duration \_\_\_\_\_

**Medications**

OTHER THAN OVER THE COUNTER MEDICATIONS, will the camper require medications during their stay at Camp Virginia Jaycee?

Yes  No

If 'Yes', Please List: \_\_\_\_\_  
\_\_\_\_\_

If your camper is being sent with **ANY MEDICATIONS**, please complete the **Camper Health Information Form B** and be familiar with the packaging restrictions necessary. **PRESCRIPTION MEDICATION MUST BE IN IT'S ORIGINAL PACKAGING.**

Does the camper use a service animal?  Yes  No      Can they attend camp without the animal?  Yes  No

**Allergies:**

List all known allergies, including medications, food, insects, etc. \_\_\_\_\_

Describe reaction to allergies: \_\_\_\_\_

How do you know when camper does not feel well? \_\_\_\_\_

Operations or Serious Injuries (list along with approximate date). \_\_\_\_\_

Chronic or Recurring Illness: \_\_\_\_\_

**BEHAVIOR MANAGEMENT:** (mark an "x" for all that apply)

- is hyperactive  may become homesick  likes to be center of attention  may use foul language
- prefers to work alone  may become aggressive when upset  may be stubborn  does not like to be touched
- Is controlled with medication  may express self physically, i.e. hugs often  Public Self-Stimulation

Management strategies that work at home or school: (explain what works best for you) \_\_\_\_\_  
\_\_\_\_\_

**IF CAMPER HAS A BEHAVIOR PLAN, PLEASE ATTACH A COPY.**

**USE THIS SPACE TO TELL US ABOUT YOUR CAMPER**

Communication style and system: \_\_\_\_\_

Social interactions: \_\_\_\_\_

Stress triggers: \_\_\_\_\_

Repetitive behaviors and special interests: \_\_\_\_\_

Behavior management techniques used: \_\_\_\_\_

Calming activities: \_\_\_\_\_

Motivators: \_\_\_\_\_

Typical morning routine: \_\_\_\_\_

Typical bedtime routine: \_\_\_\_\_

**DAILY LIVING SKILLS** Please complete with as much detail as possible.

**Eating:** (mark an "x" for all that apply)

- no assistance needed  some assistance needed  total assistance needed
- difficulty swallowing solids  needs Thick-It  needs food blended  needs food chopped
- has a tongue thrust  uses a straw  assist with cutting  will provide special utensils
- difficulty swallowing liquids  needs assistance with drinking

requires a special diet \_\_\_\_\_

other \_\_\_\_\_

**Personal Care:** (mark an "x" for level of assistance needed)

- Dressing:**  none  some assistance  total assistance    **Bathing:**  some assistance  total assistance
- Combing Hair:**  some assistance  total assistance    **Brushing Teeth:**  none  some assistance  total assistance
- Toileting:**  none  some assistance  total assistance    **Transferring:**  none  some assistance  total assistance

Does camper wear dentures?  Yes  No    Does camper wear diapers/Depends?  Yes  No

Does camper have a catheter?  Yes  No    If 'Yes'  internal?  External?  some assistance?  total assistance?

Type of catheter: \_\_\_\_\_

**Females:** Does the camper have a menstrual cycle  Yes  No    Can she care for herself?  Yes  No

**Mobility:** (mark an "x" for all that apply)

- walks alone  walks with assistance  walks with crutches/walker/cane  uses manual wheelchair
- electric wheelchair  Is not ambulatory  other \_\_\_\_\_

**Special Appliances:** Does the camper use or wear any special appliances? (leg braces, colostomy bag, Hoyer Lift, etc.)  Yes  No

If 'Yes', please explain: \_\_\_\_\_

**COMMUNICATION AND SENSES**

Check the statements that best describe the applicant's communicative ability:

- Verbal:**  speaks clearly  may be difficult to understand  uses only a few words  talks in sentences
- sometimes uses sentences
- Non Verbal** (mark an "x" for all that apply):  writes  uses a communication board  uses sign language only
- uses signs  uses signs and a few words  uses gestures  uses eyes

If the applicant is non-verbal, does s/he use any special signs? \_\_\_\_\_

**Eyesight:** (mark an "x" for all that apply):

- 20/20 vision  some vision  legally blind
- wears glasses  will bring glasses to camp  will not bring glasses to camp

Special instructions: \_\_\_\_\_

**Hearing:** (mark an "x" for all that apply)

- normal hearing  some hearing  Hearing impaired (fully)
- wears a hearing aid (left ear)  wears a hearing aid (right ear)  will not bring aid(s) to camp

Special instructions: \_\_\_\_\_

**Sleeping &/or Miscellaneous** (mark an "x" for all that apply)

- Does camper sleep through the night?  Yes  No
- Does camper require a nap during the day?  Yes  No
- Does the camper use a C-Pac machine?  Yes  No

Does camper have any special needs at night? (positioning, sleeping, toileting, equipment) Please explain: \_\_\_\_\_

Does camper have any known fears?  Yes  No Please list:

### CAMP ACTIVITIES

Please indicate the applicant's experience with activities, providing any information that would be helpful for our staff:

**Swimming:** Does the camper have a fear of the water?  Yes  No

Abilities (mark an "x" for all that apply)  swims well  limited swimming skills  does not know how to swim

uses flotation devices &/or PFD  will provide floats  shallow end only  cannot get head wet  has tubes in ears

**NO SWIMMING**

**Restrictions While At Camp:** List any camp activities the applicant should not attempt (with Doctor's counsel): \_\_\_\_\_

### ADDITIONAL RELEVANT INFORMATION

### SECTION 3 INSURANCE INFORMATION

Please attach a photocopy of the front and back of the Insurance, Medicaid, or Medicare card.

Name of Insurance Carrier: \_\_\_\_\_

Policy, Medicare, or Medicaid Number: \_\_\_\_\_, Group Number: \_\_\_\_\_

Are immunizations current?  Yes  No Date of last Tetanus immunization: \_\_\_\_\_

### SECTION 4 CONSENT TO PARTICIPATE IN CAMP VIRGINIA JAYCEE PROGRAM

Camp Virginia Jaycee would like to be able to accept every individual that applies, but we often receive more interest than available space, or direct care staff! All applications are subject to a medical review by our Health Officer/Medical Director, Camp Director, and Program Director. Considerations regarding acceptance may be based on the individual's inability to attend a typical camp, degree of the medical support needed, the severity of the disability, and/or other factors. Camp Virginia Jaycee reserves the right to make all decisions on campers' acceptance and participation.

Form Prepared By: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ ext: \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Address: \_\_\_\_\_ E-Mail Address \_\_\_\_\_

\_\_\_\_\_ Alternate Phone # (\_\_\_\_) \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_

How did you hear about Camp Virginia Jaycee? \_\_\_\_\_

This camper consent form is correct and complete to the best of my knowledge and the person herein described has permission to engage in all camp activities except as noted.

Signature of responsible parent/guardian:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

### PHYSICIAN'S AUTHORIZATION

Name of Family Physician \_\_\_\_\_

I have examined the person herein described and reviewed his/her health history. It is my opinion he/she is able to engage in all camp activities, except as stated.

\_\_\_\_\_  
Signature of examining physician

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Phone number, including area code

\_\_\_\_\_  
Mailing address

\_\_\_\_\_  
Date of exam