Camp Echoing Hills

Annual Respite Participant Application

Application must be completed in full, signed and mailed or faxed to Camp office prior to attending. Incomplete applications will be returned.

General Information

Applicant's Full Name

____

Phone (_____)________________

Street Address

____

City

____

State ___________ Zip ______________

County ____________________________

Sex ______ Height _______ Weight ________

Date of Birth ___________Age ________

Is applicant their own guardian? Yes__ No__

Parent/Guardian Name

____

Relationship ___________________________

Phone (_____)________________

Cell Phone (_____)________________

Parent/Guardian Address

____

City ___________________________________

State ___________ Zip __________

County ________________________________

Email__________________________________

Parent/Guardian Place of Employment

____

Phone (_____)________________

Agency/Facility Serving Applicant

____

House Manager _________________________

Phone (_____)__________________________

Contact after hours ______________________

Address _______________________________

City _________________ State ___________

Zip ___________ County ______________

SSA/Service Facilitator/Third Party Funding Contact

Name _________________________________

County ________________________________

Phone (_____)__________________________

Email __________________________________

Waiver (circle one) Level 1 IO OHC Transitions Self

HAS APPLICANT ATTENDED CAMP ECHOING HILLS BEFORE? Yes ___ No ___

When? ___________

Applicant's SS# ____________________

Medicaid # ____________________________

Medicare # ____________________________

Applicant's Insurance Company

____

Policy # ______________________

Who should we contact if we have questions regarding this application?

Name _______________________ Best Contact # ____________________

Email____

Dates of Camp Respite applying for: ___________________________

Please Mail or Email Application to:

Camp Echoing Hills●36272 CR 79 Warsaw, OH 43844●esmith@ehvi.org

Fax – 740.327.2333

Emergency Contacts

We will attempt to contact Parent/Guardian first. Please List 2 additional contacts.

Name ______________________________
Relationship_________________________
Work Phone _________________________
Home Phone _________________________
Cell Phone __________________________

Name ______________________________
Relationship_________________________
Work Phone _________________________
Home Phone _________________________
Cell Phone __________________________

Pick up Authorization

I authorize my child/adult to be released/picked up only by the following persons. Please include parents if applicable. I will notify Camp Echoing Hills of any changes in this information.

Please do not leave this section blank

Name ______________________________ Relationship ______________________________
Name ______________________________ Relationship ______________________________
Name ______________________________ Relationship ______________________________
Name ______________________________ Relationship ______________________________

How would you like to pay for your services?

Funding Contact/Service Facilitator/SSA Name ____

Funding Contact/Service Facilitator/SSA Email ____

Funding Contact/Service Facilitator/SSA Phone (______)____________________________________

☐ Cash Payment

☐ Check or Money Order

☐ Requesting Campership

☐ Local Lions Club

☐ County Contract

We must have all necessary documentation for individuals on waivers. Those who do not provide all documentation will not be allowed to attend camp. PAWS must be posted 2 weeks prior to camp attendance.

Third Party Funding Source

Please check the following

☐ Waiver Level One (L1)

☐ Waiver Independent Options (IO)

☐ Waiver Ohio Home Care

☐ Waiver Transitions

☐ Waiver Self

Does individual have a behavioral or medical add on? Yes (   ) No (   )

You must provide camper ISP and Behavior Plan along with application.

If you checked waiver:

1. Please provide the contact information above
2. Notify the funding source of intentions to enroll at Camp Echoing Hills
3. Have funding source forward a copy of the annual plan to Emily Smith at:

esmith@ehvi.org

I LIKE TO DO:

_____ Archery
_____ Paintball
_____ Go-Carts
_____ Board/Card Games
_____ Crafts
_____ Dancing
_____ Fishing
_____ Group Activities
_____ Nature Exploration
_____ Sensory Activities
_____ Singing
_____ Sports
_____ Swimming
_____ Other
____
____

I COULD BECOME UPSET BECAUSE:

_____ I am too hot or cold
_____ I am not getting my way
_____ I am being told "no"
_____ I am being asked to wait
_____ I am afraid
_____ I am being asked to take turns
_____ I am trying to communicate and am not being understood
_____ There is a change in my schedule
_____ Someone is bossing me around
_____ I am in a crowd
_____ I am ill / In pain
_____ I am hungry or thirsty
_____ I am asked to share
_____ Other
____
____

I COMMUNICATE BEST:

_____ Non Verbal
_____ Verbally
_____ Writing Notes
_____ Using sign language
_____ Using gestures/pointing
_____ Using simple words
_____ Using body language and facial expressions
_____ Using a communication device
Will this be sent to camp?
Yes ___ No ___

I DO NOT LIKE OR MAY BE AFRAID OF:

_____ Animals ___________________________
_____ Change in schedule
_____ Insects
_____ Large Groups
_____ Loud Noises
_____ Nurses/Doctors
_____ Showers
_____ Storms
_____ The Dark
_____ Toileting
_____ Water
_____ Other
____
____

MY FRUSTRATIONS MAY APPEAR BY:

_____ Bad language
_____ Biting self or others
_____ Crying
_____ Hair pulling
_____ Hiding
_____ Hitting
_____ Kicking
_____ Inappropriate Touch
_____ Refusing to move
_____ Running away
_____ Scratching
_____ Screaming
_____ Spitting
_____ Throwing things
_____ Undressing
_____ Wandering
_____ Other
____
____

YOU CAN HELP ME BY:

_____ Offering Quiet space
_____ Offer me choices
_____ Speaking calmly and quietly
_____ Use fewer words
_____ Take a break
_____ Use picture schedule
_____ Provide pressure
_____ Provide sensory input (jumping, running, splashing)
_____ Talk to me about why I am upset
_____ Use first/then statements

I have a behavior plan ___ Yes ___ No

I may exhibit sexual behavior: ___Yes ___ No
Explain__________________________________
____

APPLICANT'S DISABILITY AND PRESENT CONDITION

Cause and onset of disability: At birth _______ Illness _______(year _____) Accident _______(year _____)

Please give diagnosis and fully describe the extent and degree of disability: ________________________

____

MOBILITY (please check all that apply)

Normal Walking	( )	Cane(s)	( )	Walker	( )
Slow Walking	( )	Crutches	( )	Hoyer Lift	( )
Unsteady Walking	( )	Wheelchair - Manual	( )	Legs Bear Weight	( )
No Walking	( )	- Electric	( )		

Braces ( ) -- When are they worn? ____

Describe best way to transfer applicant from wheelchair: ________________________________

____

Please note: Camp Echoing Hills cannot provide wheelchairs or hoyer lifts. All wheelchairs must have a safety belt to protect the applicant. Always check wheelchairs before an event to assure safe working order.

EATING (please check all that apply)

Eats independently ( ) Has trouble swallowing: Solid foods ( ) Liquids ( )

Needs help eating ( ) Needs to be fed: Some foods ( ) All food ( )

Needs food cut up ( ) Needs to eat: Mechanical Soft foods ( ) Pureed foods ( )

Uses straw for liquids ( ) Describe appetite: Poor ( ) Normal ( ) Overeats ( )

Uses gastronomy tube ( ) Please describe any adaptive eating equipment: ____________________

____

Is applicant diabetic? Yes ( ) No ( ) If yes, specify diet restrictions: ____________________________

____

Note: Please send the necessary supplies for testing.

Please describe any food allergies: ____

____

Foods to avoid because they cause hyperactivity, headaches, etc…:

____

Other information regarding applicants eating habits: ______________________________________

____

Please note: Camp Echoing Hills will modify diets if there is a specific medical need to do so. Every effort is made to monitor amounts served, but we may not be able to adhere to general weight restricting diets.

SLEEPING ARRANGEMENTS (please check all that apply)

Sleeps through night ( ) Sleeps with side rails ( ) Prone to bad dreams ( )

Wets bed: Never ( ) Occasionally ( ) Frequently ( )

Please explain how bedwetting is handled: ____

____

Other information on sleeping arrangements: ____

____

APPLICANT PERSONAL CARE AND HYGIENE (please check all that apply)

	Independent	Needs Help	Total Care	Comments
Dressing	( )	( )	( )	______________
Showering	( )	( )	( )	______________
Washing Hands & Face	( )	( )	( )	______________
Brushing Teeth	( )	( )	( )	______________
Shaving	( )	( )	( )	______________
Washing Hair	( )	( )	( )	______________
Tying Shoes	( )	( )	( )	______________
Using Toilet	( )	( )	( )	______________
Menstruation (women only)	( )	( )	( )	______________

Other information regarding personal care: ____

____

TOILETING NEEDS (please check all that apply)

Uses: Portable urinal ( ) Bed pan ( ) Catheter ( ) Type ______________________
Uses: Briefs ( ) Plastic pants ( ) Liners ( ) When: Night only ( ) Occasionally ( ) Always ( )

If applicant has occasional constipation, how is it managed? ______________________________

Other information regarding toileting needs: ____

____

***SWIMMING** (please check all that apply) *Note: Pool is only 5' deep

Swims independently ( ) Enjoys water, cannot swim ( ) Wears life jacket ( )
Wears ear plugs ( ) Fears water ( ) Seizure prone in water ( )
Needs one-on-one attention in pool ( ) Not allowed in pool at all ( ) No life jacket needed ( )

Please note: If applicant has toileting accidents or uses briefs, please send swim briefs or 4-6 cloth briefs with elastic pants for use in pool. Disposable products may not be used in the pool.

MEDICAL INFORMATION (please fill in all applicable information)

Does the applicant sunburn easily? Yes ( ) No ( ) If yes, list restrictions that apply: __________

____

Is applicant allergic to bee stings or other insect bites? Yes ( ) No ( ) If yes, please describe the reaction and how it should be treated: ____

Does applicant use an Epi-pen?_______ Camper must bring any needed supplies, properly labeled.

Should applicant avoid exertion due to heart or other health concerns? ________________________

Please describe other allergies, health concerns or sensitivities that may hinder applicant's participation: ___

____

Does the applicant have Asthma? Yes ( ) No ( )
Please list medications, inhalers, etc. and how they are used ______________________________

____

***Illnesses applicant has had:** (please check all that apply)

Frequent Colds ( ) Frequent Sore Throat ( ) Ear Infections ( ) Fainting Spells ( ) Skin Rashes ( )
Heart Disease ( ) High/Low Blood Pres. ( ) Breathing Problems ( )

Please explain any chronic or recurring illnesses, rashes or infections:

____

***Seizures and Convulsions**
Does applicant have a history of seizures? Yes ( ) No ( ) If yes, how often? ____________________
Please describe a typical seizure, medication used and precautions for reducing onset of seizures: _________

____

***Medication Allergies and Restrictions**
Known medication allergies of applicant: ____

____

Please describe any other medication restrictions or sensitivities: __________________________________

____

Can applicant use acetaminophen for minor problems (headache, low grade fever)? ____________________

***Bed Sores -** Does applicant have bedsores, pressure areas or decubitis that is being treated? ___________

If yes, please specify location of area and describe treatment: _____________________________________

Applicant's Physician's Name ___________________________________ Phone (_____)_______________

Most recent physical exam, date and findings: ____

____

(OHC and Transitions Waiver Individuals only) This application serves as A Plan of Care with doctor signature.

Diagnosis: ________________________________ Diagnosis Code: _____________________

Physician Signature ____

REGISTRATION TIME FOR WEEKEND RESPITE IS 6:30 PM ON FRIDAY.
CHECK-OUT TIME IS 1:30 P.M. ON SUNDAY.

PLEASE NOTE:

- This application must be completed in full, (BSP and ISP are considered part of the application process). Incomplete applications will not be processed and will be returned.
- Application MUST be signed by the applicant's guardian if the applicant is not their own guardian.
- Camp Echoing Hills does not provide medications or personal supplies. ALL MEDICATIONS MUST BE CHECKED IN AT REGISTRATION. Any items purchased will be charged to the applicant or payee.
- Applicant assumes responsibility for any damages that they cause to persons or property.
- It is our policy that all individuals receive constant supervision while on camp grounds.
- Any Applicant leaving Camp early for any reason will not receive a refund of any monies.

"I have read and understand the above listed unalterable terms. Applicant has my permission to attend and participate in the above named Camp activity. Camp Echoing Hills has my authorization to use the designated Camp physician for emergency treatment for the applicant. Medical information may be released by the attending physician as given on this application."

Signature of Parent/Guardian ____ Date _______________