CAMP ECHOING HILLS

Summer Camp Participant Application

COMPLETE APPLICATIONS are due as soon as possible.

Applicant's Full Name _____ Date of Birth _____ Age _____

Street Address _____ City _____

State _____ Zip _____ County _____

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 _____ Phone (_____)_____

House Manager _____ Contact after hours _____

Address _____ City _____ State _____ Zip _____ County _____

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

Who should we contact if we have questions regarding this application?
Name _____ Best Contact # _____
Email_____

Camp Weeks applying for: 1st Choice_____ 2nd Choice _____

Purchasing a T-Shirt? Camp shirts can be ordered up until May 1st. T-Shirts will not be ordered for your camper without receiving payment by May 1st.

T-Shirt Order: Small – X Large $15.00 **Size _____**

T-Shirt Order: 2X or Larger $17.00 **Size _____**

Please Mail the application to:
Camp Echoing Hills•36272 CR 79 Warsaw, OH 43844
E-Mail dkpeterson@ehvi.org • Fax 740.327.2333

In Case of Emergency

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

Name _____
Relationship_____
Work Phone _____
Home Phone _____
Cell Phone _____

Name _____
Relationship_____
Work Phone _____
Home Phone _____
Cell Phone _____

Applicant's SS# _____ Medicaid # _____
Medicaid Effective Date: _____ Medicare # _____
Applicant's Insurance Company _____ Policy # _____

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 _____

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

□ Local Lions Club

□ County Contract

□ Requesting Campership

We cannot guarantee that you will receive the funds you request. Those who have the greatest financial need will take priority. Please contact us if you need a campership form.

□ Third Party Funding Source
Please check the following

□ Waiver Level One (L1)
□ Waiver Independent Options (IO)
□ Self Waiver

Please list staff to camper ratio specified on waiver ISP: _____

If you checked waiver:

1. Please provide the contact information above
2. Notify the SSA or County of intentions to enroll your camper at Camp Echoing Hills
3. Have funding source forward a copy of the annual plan to Camp Echoing Hills.

***Note: If you do not contact your SSA you may be billed for the entire camp fee.*

We must have all necessary documentation for individuals on waivers. Those who do not provide all documentation will not be allowed to attend camp.

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: _____

_____

MEDICAL INFORMATION (please fill in all applicable information) Sex ____ Height _____ Weight _____

***DIABETES:** Is Applicant Diabetic? : Yes ( ) No ( ) How is Diabetes being controlled? _____
Applicant's typical blood sugar range? _____ Testing schedule?(How often) :_____

_____

Does applicants use a sliding scale? : Yes ( ) No ( ) *Please send copy of sliding scale to camp if applicable.*
Any additional information we should know pertaining to applicant's diabetes? : _____

_____

Note: Please send the necessary supplies for testing.

***Seizures and Convulsions**

Does applicant have a history of seizures? Yes ( ) No ( ) If yes, how often? _____
What type(s) of seizure does camper have? _____ How long do they last? _____

Please describe a typical seizure, medication used and precautions for reducing onset of seizures:

_____

_____

What are seizures triggered by?: _____ Please explain: _____

_____

Are there special precautions to be taken, such as wearing protective headgear? _____
Have seizures medications been changed recently?_____ Is there a protocol to be followed for frequent or prolonged seizures?: _____ Please explain: _____

***Allergies**

Medication Allergies: _____
Food Allergies: _____
Other Known Allergies: _____

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? _____ What is Epi-Pen used for? _____
Camp Echoing Hills does not provide Epi-pen injection supplies. Camper must bring any needed supplies, properly labeled and identified.

***Medication Information**

Does the camper experience any side effects from their medication i.e. mood behavior changes, upset stomach, etc.? Yes ( ) No ( )
List below any special instructions or additional information regarding the medications that would be helpful to Health Care Staff.

_____

_____

How are medications given? With Water ___ With Juice ___ With Pudding ___ With Applesauce ___

Through G-Tube/J-Tube ___ Other _____

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

***Other Medical Information**

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

_____

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 ( )
What causes an asthma attack? _____
What is your procedure following asthma attack? _____

Please list asthma medications, inhalers, etc. and how they are used _____

_____

**Does applicant have bedsores, pressure areas or decubitus ulcers that are being treated? _____

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

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

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

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

_____

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

Most recent physical exam, date and findings: _____

_____

MOBILITY (please check all that apply)

Normal Walking	( )	Cane(s)	( )	Uses a 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. 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	( )	Thickened Liquids: ( ) Liquid Consistency _____			

Please describe any adaptive eating equipment: _____

_____

Please describe any food allergies or food to avoid: _____

_____

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 ( ) Wanders in the night ( )
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 ( )
Needs life jacket ( )
Wears ear plugs ( )
Fears water ( )
Does not need Life jacket ( )
Needs one-on-one attention in pool ( )
Not allowed in pool at all ( )
Seizure Prone in Water ( )

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.

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
(Must be sent prior to camp)*
I may exhibit sexual behavior: ___Yes ___ No
Explain_____

_____

REGISTRATION TIME FOR SUMMER CAMP IS 1:30PM – 3:30PM ON SUNDAY.
CHECK-OUT TIME IS 1:30PM ON FRIDAY.

PLEASE INITIAL AND SIGN:

- This application must be completed AND SIGNED in full and sent with the $70 application fee. This application is considered incomplete until the entire form has been filled out. Incomplete applications will be returned. Please include a picture of the camper for identification purposes. **Initial ____**
- Application MUST be signed by the applicant's guardian if the applicant is not their own guardian. **Initial____**
- 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. **Initial____**
- Applicant assumes responsibility for any damages that they cause to persons or property. **Initial____**
- Camp Echoing Hills is not responsible for any lost items. *Please label all individual's belongings accordingly.* **Initial ____**
- Camp Echoing Hills provides 100% supervision while at camp. **Initial____**
- Camper's ISP must be sent to camp before camper attends camp week.(Waiver clients only) **Initial____**

COMPLETE APPLICATIONS are due as soon as possible. We will not guarantee a spot until the completed application has been received. A completed application entails:

- Application Form (Completely filled out. Incomplete applications will be returned.)
- Individual Support Plan (ISP) if you are using your waiver to pay your camp fee.
- Behavior Support Plan (BSP) if applicable.

"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 _____
(Or camper if own guardian)

**** Please keep a copy of this form for your records.****