



Respite 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 _____

Respite Weekends applying for: _____



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? : _____

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 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) () | 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 () | 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 ()
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 () Fears water () Not allowed in pool at all ()
Enjoys water, cannot swim () Does not need Life jacket () Seizure Prone in Water ()
Needs life jacket () Needs one-on-one attention in
Wears ear plugs () pool ()

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

PLEASE INITIAL AND SIGN:

- This application must be completed AND SIGNED in full. 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.****

