Shepherds Camp 2009

Arrowhead Bible Camp

Brackney, Pennsylvania

Office Use Only
Rec'd ____________
Medical ___________
Amount: __________
____

Application & Registration Form

Camper ______________________________________ Age _____ ❑ M ❑ F DOB ___/___/___
Address______________________________________ Phone ( ) ______-______________
City ________________ State _____ Zip _________

Adult T- Shirt Size: (Circle One) XXL XL L M S Nickname ________________________

Camper's mailing address (if different from above)______________________________________
City___________________ State _____ Zip __________ Phone ( ) ______-______________

Has the camper attended Arrowhead before? ❑ Yes ❑ No Last year attended: ❑ 2008 ❑ _____

Care Provider ____ Phone ( ) ______-_________
Address _______________________________ City _________________ State ____ Zip___________
Care Provider E-mail address: ____________________________________
Relationship to Camper: (FCP, parent, sibling, House Manager, etc.) _________________________

Please Check Program(s) Desired:

1 Week Programs

Sunday June 14th, 3:00 PM - Friday June 19th, 1:30 PM
Sunday June 21st, 3:00 PM - Friday June 26th, 1:30 PM
Cost per week $325.00
Registration Fee $100.00 Due with Registration - Non-Refundable
Balance $225.00 (includes Snack Shop, Camp Photo & T-shirt) Due June 1
Call for availability of other 1-week programs if these weeks do not fit your summer

2 Week Programs

❑ Sunday June 14th, 3:00 PM - Friday June 26th, 1:30 PM
❑ Sunday June 28th, 3:00 PM - Friday July 10th, 1:30 PM
❑ Sunday July 26th, 3:00 PM - Friday August 7th, 1:30 PM
Total Cost: $650.00
Registration Fee $100.00 Due with Registration - Non-Refundable
Balance $550.00 (includes Snack Shop, Camp Photo & T-shirt) Due June 1

Make check or money order payable to: Arrowhead Bible Camp
Mail to: Shepherds Camp, Arrowhead Bible Camp, RR 1 Box 3250, Brackney, PA 18812

The Shepherds Program accepts teenagers and adults with developmental disabilities who are without aggressive behavior, who can communicate their needs, who are ambulatory and independent in eating and toileting. Shepherds Camp is unable to accept campers limited to wheelchairs. The camper should be able to participate in the program. Rules for acceptance and participation in the program are the same for everyone without regard to race, color, sex, age, or national origins.

Questions? Call - (570) 663-2419 **www.shepherdscamp.org**

Camper Profile - please complete to the best of your knowledge

1. Mobility (please check all that apply)

Normal Walking ☐ Cane(s) ☐ Braces ☐ When are they worn? ________________
Slow Walking ☐ Crutches ☐ Other information concerning mobility: ______________
Unsteady Walking ☐ Wheelchair ☐ ____
No Walking ☐ Walker ☐ ____

2. Sleeping Arrangements (please check all that apply)

Does the camper require hourly night time bed checks? Yes ☐ No ☐ If yes, camper must be bunked in the dorms.
Camper requests to be bunked with ____
Camper requests to stay in a: Cabin ☐ Dorm ☐ - Please note that the dorms are **upstairs** in the main building.

Shepherds Camp will try our best to honor these requests.

Wets Bed: Never ☐ Occasionally ☐ Frequently ☐
Please explain how bed-wetting is handled: ____
____

Sleeps through the night ☐ Has Nightmares ☐ Needs to be awakened to use the toilet ☐

3. Communication (please check all that apply)

Normal Speech ☐ Sign Language ☐ No Speech ☐
Impaired Speech ☐ Communication Board/Book ☐ Hearing Aids ☐
Please describe any fears the individual may have? ____

4. Eating (please check all that apply) - Please note Shepherds is unable to prepare special diets.

Eats independently ☐ Please describe the camper's appetite: *poor* ☐ *normal* ☐ *overeats* ☐
Needs help eating ☐ Has trouble swallowing: *solid foods* ☐ *liquids* ☐
Needs food cut up ☐ Needs to eat: *chopped foods* ☐ *pureed foods* ☐
Uses straw for liquids ☐ Needs to be fed: *some foods* ☐ *all foods* ☐

Please describe any special/adaptive eating equipment: ____

Is the individual diabetic? ☐ Yes ☐ No If yes, specify diet restrictions/modifications: ______________
____

Please explain any other information regarding eating habits: ____
____

Please Note: Camp staff will make every effort to monitor the amount of food/liquid served to the camper. However the camp may not be able to adhere to general weight restricting diets.

5. Personal Care/Hygiene: (please check all that apply)

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

Does the individual wear glasses? Yes ☐ No ☐
Does the individual wear Dentures? Yes ☐ No ☐
Please provide any other necessary information: ____
____

6. Toileting Needs (please check all that apply)

☐ Uses Diapers If yes: ☐ *At night only* ☐ *Occasionally* ☐ *Always*
☐ Uses Portable Urinal at Night
Other information regarding toileting needs: ____

Camper Profile – Continued

7. Personality and Behavior (please check all that apply)

☐ Excitable	☐ Listens	☐ Participates	☐ Cooperative
☐ Stubborn	☐ Follows Instructions	☐ Needs to be watched	☐ Inquisitive
☐ Tantrums	☐ Active	☐ Refuses	☐ Quiet
☐ Passive	☐ Helpful	☐ Behaves	☐ PICA

Please describe any of the above or any other unusual behaviors to watch for. Also detail any behavior modification techniques that you recommend for dealing with specific behaviors: ____
____
____
____

If the camper is prone to wander, please describe the behavior and detail any recommendations for dealing with this behavior in the camp environment: ____
____
____

Is the camper attending school? Yes ☐ No ☐ If yes, grade level and school ____________________________
Is the camper employed? Yes ☐ No ☐ If yes, type/location of employment ________________________

8. Program Information

What activities does the camper enjoy? ____
____

What activities does the camper NOT enjoy? ____
____

Does the camper sunburn easily? Yes ☐ No ☐ If yes, please list restrictions: __________________________________
____

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

Should the camper avoid exertion due to heart or other health concerns? ____
Please describe any other allergies or health concerns that may hinder the campers participation: ___________________
____

Swimming: (please check all that apply) Note: A certified lifeguard is on duty at all times the waterfront is open.

☐ Enjoys water ☐ Fears water ☐ Must wear earplugs ☐ Seizure prone in water
☐ Swims independently ☐ Cannot swim ☐ Limited Ability ☐ Needs 1:1 supervision
☐ Paddle Boat use (assisted by a staff person in the boat and wearing a life jacket at all times)
☐ Shallow End swimming (0-4 feet deep) ☐ Must wear life jacket in shallow end
☐ Deep End swimming (over 6 feet deep) ☐ Must wear life jacket in deep end

Please note: All campers requesting to swim in the deep end will be given a swim test by the life guard. The life guard or camp director may refuse any camper admission to the water or waterfront.

Spiritual Programming: Shepherds camp is an interdenominational Christian ministry.
Camper's religious preference/denomination: ____

Activity Restrictions

Please review the following camp activities and determine whether the camper may participate. Please contact the camp office with any questions. All activities are closely supervised and modified to fit the camper's individual ability level.

Activity	Yes		No		Activity	Yes		No	
Adaptive Archery	Yes	( )	No	( )	Basketball	Yes	( )	No	( )
Volleyball	Yes	( )	No	( )	Nature Walks/Hikes	Yes	( )	No	( )
Kickball	Yes	( )	No	( )	Soccer	Yes	( )	No	( )
Fishing	Yes	( )	No	( )	Hay Ride	Yes	( )	No	( )

9. Medical Information

Please enclose a completed medical/physical form with the Application/Registration Form. If you are unable to do so please state why and give date that the physical is scheduled.

Reason: ____ Date Scheduled: ________________

10. Emergency Contact Information - Registrations will not be processed without this information!

Is the primary care provider planning to be away during the camp sessions?

❏ No, the primary care provider will be the contact person during the camp session.

❏ Yes, the primary care provider will be away during the camp session and has informed the 24 hour contact person that they will be on call.

Emergency Contact Person - 24 hour coverage - other than primary care provider which will be contacted first:

Name: _________________________ Relationship to Camper: _________________ Phone: (___) ____-________

Social Worker/Case Worker: ____ Phone: (___) ____-________

Other names/numbers: ____

11. Permission/Medical Release/Authorization for Treatment

The following must be signed by custodial parent/guardian, care provider, or camper if self guardian.

1. The camper listed above has my permission to attend and participate in the above named camp activity.

2. I have completed the preceding forms completely and to the best of my knowledge.

3. I grant permission for the Camp Nurse to treat minor illnesses and dispense campers' medication. I understand all medication must be given to and dispensed by the Camp Nurse.

4. I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment, and necessary transportation for the above named individual. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the individual as named above.

5. I attest to the fact that the above named individual is free of any communicable disease prior to attending camp.

6. I give permission for the camper's picture to be used in camp promotional materials.

Signature: ____________________________________ Please print name: ____________________________

Date: ____

After review of the preceding information, the camp director will make a decision regarding acceptance into the camp program. If the camper is accepted, you will receive a confirmation letter, medicine administration form, and list of what to bring to camp. The primary care provider will be contacted if the camp director has any concerns regarding acceptance. The registration fee will be refunded if the camper is denied acceptance to the program.

Additional forms available on request or at: **www.shepherdscamp.org**

Shepherds Camp
Consent for Non-Prescription Medications

Summer 2009 - for use during camp stay only

Camper's Name: ______________________________

This is a list of commonly used over the counter medications that are stocked at camp. Please check each medication that the camper may receive while at camp. The Camp Nurse dispenses all medications and notes them on the camper's medication sheet.

_________ Tylenol: (acetaminophen) 2 tablets (325 mg) by mouth for headache or temperature of 101F or over, or for c/o minor pain, every 4 hours as needed (PRN). Maximum Daily Dose (MDD) 12 tabs per day. Not to exceed 2 days.

_________ Ibuprofen: 1 tablet (200 mg) by mouth every 4 hours for muscle aches (given with food) not to give simultaneously with other analgesics (i.e. Tylenol or Aspirin). Not to exceed 2 days. Maximum daily dose 6 tabs.

_________ Bacitracin Ointment: Apply a small amount to affected area for minor skin abrasions to open sores BID as needed. Not to exceed 2 days. Maximum daily dose 2 times per day.

_________ Calamine Lotion: Moisten cotton or soft cloth with lotion and apply to affected areas to alleviate itching, to rash area, or bug bites TID as needed. Not to exceed 2 days. Maximum daily dose 3 times per day.

_________ Robitussin: Administer 2 tsp. Every 4 hours as needed for cough. Not to exceed 2 days. Maximum daily dose 12 tsp. per day.

_________ Maalox/Mylanta: Administer 2 tsp. By mouth as needed between meals, at HS for indigestion. Not to exceed 2 days. Maximum Daily Dose 4 to 8 tsp. per day.

_________ Pepto-Bismol (bismuth subsalicylate): 2 Tbsp. by mouth every hour as needed for stomach upset and/or diarrhea. Not to exceed 8 doses in 24 hours, or use until diarrhea stops but not more than 2 days.

_________ Cough drops for minor throat irritation/sore throat. 1 drop every 2 hours not to exceed 6 per day over 2 day period.

Parent/Care Provider Signature: ____

Physician Signature (if required*): ______________________________________

Date: ______________________

only needed if required by your agency/home/department.

PARENT / GUARDIAN / CARE PROVIDER

Shepherds Camp 2009 **Arrowhead Bible Camp**

Medical Form

Please Print

Camper ___________________________________ Age ______ ❑ M ❑ F DOB ___/___/___
Phone ( ) ______- ________

Parent/ Guardian / Care Provider Name(s)____
Insurance ___________________________________ Policy # ________________________
Your medicare/medicaid coverage or personal/family insurance would apply to all claims while at camp. However, the camp does provide Excess Medical Expense coverage.

Physician's Name ____________________________________ Phone ( ) ______- ________

List all physical disabilities, special instructions, recent injuries or sickness (give diagnosis)
____
____

Symptoms : Please check which problem areas experienced frequently by the camper and how you treat these at home. [Example: ✓ Diarrhea give Pepto Bismol]

Symptom	Remedies
❑ Nausea	____________________
❑ Nightmares	____________________
❑ Diarrhea	____________________
❑ Stomach-aches	____________________
❑ Dizziness	____________________
❑ Headaches	____________________
❑ Over fatigue	____________________
❑ Earaches	____________________
❑ Constipation	____________________

Allergies

- ❑ No Known Allergies
- ❑ Foods________________________
- ❑ Penicillin
- ❑ Other drug allergies ___________
- ❑ Hay fever
- ❑ Poison ivy
- ❑ Insect bites________________________
- ❑ Reaction:____________________
  (if bee sting, then the person is responsible to bring an appropriate sting kit.)
- ❑ Other allergies _____________________

Medication:

❑ Yes, the camper is regularly on medication. (Please contact your camper's Doctor regarding any medications, topical ointments, etc. that could be stopped or put on hold while at camp. A medicine administration form will be sent with the confirmation letter which must be completed and brought with the camper on arrival day.)

Seizures:

❑ Yes, the camper experiences seizures. Campers prone to seizures will be accompanied in the lake with an Arrowhead Bible Camp Staff member. If there are any other restrictions due to this occurrence, please list ___________________
Date of last seizure _______ Frequency of seizures ______________

_____________________________________ _______________
Signature of the Parent/ Guardian/ Care Provider **Date**

Mail to: Shepherds Camp, Arrowhead Bible Camp, RR1 Box 3250, Brackney, PA 18812
Please call Arrowhead Bible Camp with any questions (570) 663-2419

ATTENDING PHYSICIAN

Shepherds Camp 2009 **Arrowhead Bible Camp**

Medical Form

Please Print

Or a current **(within 1 year of camp date)** Health Physical may be attached.
Reverse side must be completed by parent/care provider.

Camper's Name ________________________________

Physician's Name ______________________________ Phone (   ) _____- __________
Address _____________________________________ State ______ Zip ______________
Hospital associated with: ____

General Physical Condition

Height _______ Weight _______ BP ________ Eyes _______ Ears _______ Lungs _______

Skin: Clear _______ Dermatitis _______ Eczema _______ Infections _______

Date of last Tetanus shot _______ Is this camper subject to seizures? ❏ No ❏ Yes

Should the camper be restricted from any camp activities? ❏ No ❏ Yes,_________________
____

Medication

Please list the medications prescribed by you **(or attach current medication list)**. If there are any medications, topical ointments, etc. that could be stopped or put on hold while at camp please inform the parent or care provider and check it on this form.

Medication _________________________ Qty _________ Frequency _____________ ❏
Medication _________________________ Qty _________ Frequency _____________ ❏
Medication _________________________ Qty _________ Frequency _____________ ❏
Medication _________________________ Qty _________ Frequency _____________ ❏

Mental Evaluation

Diagnosis ____

Further Comments: ____
____
____
____

______________________________________ ____________
Physician's Signature **Date**