



Shepherds Camp 2010

Arrowhead Bible Camp

Brackney, Pennsylvania

Application & Registration Form

Office Use Only

Rec'd _____

Medical _____

Amount: _____

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: 2009 _____

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 13th, 3:00 PM - Friday June 18th, 1:30 PM
 - Sunday June 20th, 3:00 PM - Friday June 25th, 1:30 PM
- Cost per week \$350.00 Registration Fee: \$100.00 Due with Registration - Non-Refundable*
Balance: \$250.00 (includes Snack Shop, Camp Photo & T-shirt) Due June 1st
Call for availability of other 1-week programs

2 Week Programs

- Sunday June 13th, 3:00 PM - Friday June 25th, 1:30 PM
 - Sunday June 27th, 3:00 PM - Friday July 9th, 1:30 PM
 - Sunday July 25th, 3:00 PM - Friday August 6th, 1:30 PM
- Total Cost: \$700.00 Registration Fee: \$100.00 Due with Registration - Non-Refundable*
Balance: \$600.00 (includes Snack Shop, Camp Photo & T-shirt) Due June 1st

NEW! 1 to 1 Week

[open to campers who require individual care]

- Monday July 19th, 10:00 AM - Friday July 23rd, 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 1st

Make check or money order payable to: Arrowhead Bible Camp

Mail to: Shepherds Camp, Arrowhead Bible Camp, 122 Arrowhead Cottage Rd., Brackney, PA 18812

Questions? Call - (570) 663-2419

www.shepherdscamp.org

Camper Profile - please complete to the best of your knowledge

1. 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: Cabin Dorm (*dorms are **upstairs** in the main building*)

Shepherds Camp will try our best to honor these requests.

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

- Enjoys water Fears water Must wear earplugs Seizure prone in water
- Swims independently Cannot swim Needs 1:1 supervision
- May ride in Paddle Boats (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

3. 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 _____

4. Toileting and Overnight Care (please check all that apply)

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
- Uses Diapers *If yes:* *At night only* *Occasionally* *Always*

Uses Portable Urinal at Night

Other information regarding toileting needs: _____

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

- Eats independently Describe camper's appetite: poor normal overeats
- Needs help eating Has trouble swallowing: solid foods liquids
- Needs food cut up Needs to eat food that is: chopped pureed
- 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.

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

	Independent	Needs Help	Total Care	Comments
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brushing Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Using Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Washing Hands and Face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tying Shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Menstruation (women only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does the individual wear glasses? Yes No

Does the individual wear Dentures? Yes No

Please provide any other necessary information: _____

Camper Profile – Continued

7. Communication (please check all that apply)

- Normal Speech
- Impaired Speech
- Sign Language
- Communication Board/Book
- No Speech
- Hearing Aids

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

- Active
- Excitable
- Behaves
- Listens
- Helpful
- Participates
- Cooperative
- Inquisitive
- Passive
- Quiet
- Follows Instructions
- In Need of Constant Watching
- Tantrums
- Refuses
- Stubborn
- PICA

Please describe any fears the individual may have? _____

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 _____

9. 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: _____

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.

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	()

10. 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: _____

11. 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: _____

12. 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.

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.

Shepherds Camp

Consent for Non-Prescription Medications

Summer 2010 - 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

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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]

Table with 2 columns: Symptom, Remedies. Rows include Nausea, Nightmares, Diarrhea, Stomach-aches, Dizziness, Headaches, Over fatigue, Earaches, Constipation.

Allergies section with checkboxes for No Known Allergies, Foods, Penicillin, Other drug allergies, Hay fever, Poison ivy, Insect bites, Reaction, and 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

ATTENDING PHYSICIAN

Shepherds Camp 2010

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