Camp ClapHans

Registration application

Please return completed applications to us by:
- Email: bhunter@jdmc.org
- Fax: 405-307-2801
- Mail: J.D McCarty Center Attn: Camp ClapHans 2002 E. Robinson St. Norman, OK 73071

This application is meant to assist Camp ClapHans in creating the best possible experience for campers with special needs. Please complete the sections as they apply to your child. Thank you!

Camper name: _____

Address: _____

City: _____ State: _____ ZIP _____ Phone: _____

Age: _____ Date of birth: _____ Male: _____ Female: _____

Parent or guardian: _____

Email: _____ Camper's shirt size: _____

Health insurance information:

Carrier: _____ Group number _____ ID number _____

Name of primary insured: _____

Relationship to camper: _____

Primary care doctor: _____

Phone: _____ Date of last examination: _____

Emergency contacts:

* Please list someone other than the parent/guardian listed above, and someone who will know how to contact you if we are unable to reach you.

Name: _____ Phone: _____

Relationship to camper: _____

Name: _____ Phone: _____

Relationship to camper: _____

Camp sessions: Please mark all the sessions your camper is available to attend, and we will do our best to place them in the most appropriate group of campers:

☐ **May 24- June 11** ☐ **June 14- July 2** ☐ **July 12-30** ☐ **All camp sessions**

For office use only:

RCV _____ **SCH** _____ **NRS** _____ **PHN** _____ **BAL** _____ **PSY** _____

Camper's diagnosis: *(Check all that may apply)*

☐ Asthma ☐ Down syndrome ☐ Autism ☐ Cerebral Palsy
☐ Epilepsy ☐ ADD/ADHD ☐ Diabetes: Type I or II ☐ Heart condition
☐ Asperger's ☐ Blind ☐ Dyslexia ☐ Traumatic brain injury
☐ Seizure disorder ☐ Hypertension ☐ Developmental delay ☐ Visual impairment
☐ Deaf ☐ Communication delay ☐ Obesity ☐ Learning disability
☐ Spina Bifida ☐ Intellectual disability ☐ Hearing impaired ☐ Muscular dystrophy
☐ Multiple sclerosis ☐ Other
☐ Spinal cord injury: Quadriplegic or paraplegic
☐ Breathing difficulties:

*Trach: Specify type _____

*Any important surgeries, hospitalizations or medical complications that may affect the child's camp experience? _____

_____

Medical information:

Vision

☐ Sighted/ Normal ☐ Night blindness ☐ Legally blind
☐ Partially sighted ☐ Color blind ☐ Other _____

Hearing

☐ Normal ☐ Partial hearing ☐ Legally deaf
☐ Normal with aid ☐ Partial hearing with aid ☐ Other _____

Communication

Is the camper able to understand and communicate his/her needs to others? (Ex. Food, drink, bathroom, help) ☐ Yes ☐ No

☐ Verbal ☐ Communication board ☐ PECS ☐ Gestures
☐ Non-verbal ☐ Electronic device ☐ Sign language ☐ Other

If other, please explain: _____

Mobility

☐ Ambulatory (no assist) ☐ Wheelchair- power ☐ Wheelchair- manual
☐ Cane(s) ☐ Walker

Seizure activity

☐ None ☐ Petit Mal (absence) ☐ Grand Mal (generalized tonic/clonic) ☐ Complete Partial (staring)

Frequency: _____ Duration: _____

Date of last seizure? _____

How is the seizure treated?

☐ Regular/scheduled meds ☐ Emergency meds ☐ Both

Please describe the camper before, during and after the seizure: _____

_____

_____

Transfers

☐ Standby ☐ Two person ☐ Mechanical lift ☐ Other _____

☐ Independent ☐ Stand and pivot ☐ One person total lift ☐ None

Adaptive devices

☐ None ☐ AFO's ☐ Leg braces ☐ Prosthesis

☐ Helmet ☐ Glasses ☐ Hearing aids ☐ Splint

☐ Other _____

***Parents/guardians will be asked to instruct camp staff on how to use special adaptive equipment when child arrives to camp.**

Other medical items to be aware of:

☐ Shunt ☐ Rods ☐ Other _____

Swimming

Can the camper swim with supervision? ☐ Yes ☐ No

Please describe your child's swimming experience and routine, including any required equipment:

_____

_____

_____

_____

_____

Behavior:

General disposition: (Check all that may apply)

☐ Generally easygoing ☐ Unsure of new situations ☐ Wanders

☐ Temper tantrums ☐ Shy/withdrawn ☐ Helpful

Is this your child's first time staying away from home? _____

What does your child like? What is he/she afraid of? _____

_____

_____

In your opinion, what is your child's developmental age? _____

Please indicate how often your camper exhibits the following behaviors and the consequences:

Behavior	How many times does behavior occur? Daily or monthly?	What causes behavior?	How do you address this behavior?
Scratches, pinches or hits self or others			
Bangs head			
Grabs others			
Touches others inappropriately			
Throws things			
Gets into personal belongings			
Runs away			
Climbs on furniture			
Uses inappropriate language			
Spits on others			
Dumps food or liquids			
Strips clothing			
Other			

Personal care information:

Eating

☐ No Assist ☐ Partial assist ☐ Total assist

Please describe any assistance required for feeding: _____

_____

List adaptive equipment needed for feeding: _____

_____

Diet

☐ Normal ☐ Chopped food ☐ Blended/ puree ☐ Diabetic

☐ G-Tube only ☐ G-Tube and oral foods

Food allergies or special dietary needs: _____

Does the camper have any difficulty swallowing? ☐ Yes ☐ No

List any strongly liked or disliked foods: _____

_____

Toileting

Bladder control: ☐ No assist ☐ Needs reminder ☐ Occasional accidents ☐ Incontinent ☐ Total assist

Bowel control: ☐ No assist ☐ Partial assist ☐ Total assist

Please explain home toileting routine: _____

_____

_____

Does your child wear:

☐ Underwear ☐ Pull-ups ☐ Diapers ☐ Pull-ups at night only

☐ Other _____

Bathroom aids:

☐ Urinal ☐ Toilet chair ☐ Catheter ☐ Other _____

Menstrual care

☐ Non-applicable ☐ No assist ☐ Needs reminder ☐ Partial assist ☐ Total assist

Please explain any assistance needed: _____

Washing/ showering

☐ No Assist ☐ Partial assist ☐ Total assist

Please describe bathing routine: _____

_____

Dressing

☐ No assist ☐ Partial assist ☐ Total assist

Please describe dressing routine: _____

_____

Sleeping

Sleep walks? ☐ Yes ☐ No

Needs to be awakened or turned during the night? ☐ Yes ☐ No

Other information : _____

Medication information:

Does the camper have any allergies? ☐ Medication ☐ Food ☐ Other

If yes, please list: _____

_____

Does the camper take any medication? ☐ Yes ☐ No

If yes, please list: _____

_____

_____

The following non-prescription OTC medications may be used on an as-needed basis to manage illness and injury.

Please check all that apply. Camp ClapHans has permission to give camper the following:

☐ Laxatives for constipation (Ex-Lax) ☐ Aloe vera gel, topical ☐ Calamine lotion, topical

☐ Bismuth Subsalicylate for diarrhea (Pepto-Bismol) ☐ Lice shampoo or cream (Nix or Elimite)

☐ Antibiotic cream, topical ☐ Sore throat spray ☐ Generic cough drops

☐ Diphenhydramine antihistamine/allergy medicine (Benadryl) ☐ Antihistamine/allergy medicine

☐ Dextromethorphan cough syrup (Robitussin DM) ☐ Guaifenesin cough syrup (Robitussin)

☐ Acetaminophen (Tylenol) ☐ Pseudoephedrine decongestant (Sudafed)

☐ Phenylephrine decongestant (Sudafed PE) ☐ Ibuprofen (Advil, Motrin)

Consent:

This health history is correct as far as I know. My child has my permission to engage in all camp activities, including horseback riding, unless exceptions noted:

I give my permission for medications to be administered by the nurse and understand that WRITTEN INSTRUCTIONS ARE REQUIRED. This includes prescription and non-prescription drugs, as well as topical or external applications. Medications are to be labeled and given to the nurse at the start of camp; no medications can be left with your child for self-medication.

In the event of injury, I hereby give permission to the medical personnel selected by the camp staff to order X-rays, routine tests and treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. 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 my child.

Signature of Parent/ Guardian _____

Date _____

Note: Parents/guardians, please send a current photo of your child with this application.

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