Jesus Cares Camp Phillip – 2018

JESUS CARES MINISTRIES
A MINISTRY OF THE LUTHERAN
HOME ASSOCIATION

Whooohooooo!!!! We are so glad you are interested in coming to Camp Phillip for Jesus Cares Camp! Here are a few things you need to know:

Are you eligible for camp?
Jesus Cares week at Camp Phillip is staffed with volunteers and designed for persons with mild to moderate developmental disability, who are *ambulatory*. There is significant walking at camp to and from cabins. Please consider that camp activities require some strength and stamina. *Both the cabins and the main dining hall do NOT have air conditioning*. Campers need to participate in activities as planned. Campers must have independent toileting and feeding skills and be able to walk independently. Our camp counselors are primarily young adults who may not be experienced in giving personal care such as when a camper has a toileting accident on a regular basis.

When is camp?
July 2-6, 2018. Check-in will be at 2:30pm. Please do not plan to arrive earlier than that. On departure Friday, come around 10:30am for a short service and awards ceremony with checkout to follow.

Where is camp?
W9944 Buttercup Avenue in Wautoma, WI. The phone number for Camp Phillip is (920) 787-3202. You are responsible for transportation to and from camp.

Cost
The fee for this year will be **$465.** Everyone is responsible for a **$100.00** deposit fee (payable to Camp Phillip) due with your camper forms by **May 1st.** The balance of the fee ($365) is due on the first day of camp, July 2nd. **Please make sure all pages of the forms are filled out completely, signed, and the deposit included.**

****NEW Medication requirements****

Medications will ONLY be accepted in **<u>pharmacy prepared blister/bubble</u>** packs for safety and ease of administration. The images below are the most commonly seen types of blister packs in our area. These will all be accepted at camp. If your pharmacy carries a different style, please let us know and one of our nurses will contact you.

- **What is <u>NOT acceptable</u>?** Nurses will NOT accept home fill baggies or envelopes or pill minders. Bottles will be accepted for as needed medications only and must include instructions for use from doctor.

- **Liquids and Powders:** Can be sent in original containers with current administration instructions on pharmacy label

- **As needed medications:** These medications will be accepted either in bubble packages or ORIGINAL pill bottles with current administration instructions. Expiration date must be current. *Please note that as needed medications can only be given with permission!* We do carry some products. See the over the counter section of the application.

- **Pudding/Applesauce:** Is NOT provided. Please send if this is required for medication administration.

- **Medication Lists:** Please provide printed list from provider at time of application. We realize this may change by camp, but having a general idea early will help us plan.

- **Note:** All medications will be collected and administered by nursing staff for the safety of the other campers

- ***What if I'm not sure or bubble packs are hard to get in our area?*** *Maybe one of our nurses can help! Check the appropriate box on the camp form (under medical) and one of our nurses will be in touch!*

Please make a copy of your camper's insurance card (such as Forward Health) or if they have a T-19 card provide that. Not all campers will have a T-19 card.

It is important that we get new camper forms each year. Their needs may have changed. Having complete and current forms is of great help to our staff to allow us to properly serve our guests and assure they have a great time at camp. Please complete and return the camper information packet as soon as possible!

CAMPER REGISTRATION PACKET
Jesus Cares Camp Phillip 2018

Camper Name: (First)________________________(Last)_____________ Nickname: ___________________

Address: ____

City: ____________________________ State: __________ Zip:_____________________

Phone: (_____) ____________ Email: ____

Age:_______ Date of Birth: ___/___/______ Gender: M F

T-shirt size (please circle size)**: Small / Medium / Large / XL / XXL / 3XL**

Is the patient their own guardian? ☐Yes ☐No
Camper lives (circle): Independently – With Family – With Foster Family – Group Home – Residential Facility
First time camper: ☐No ☐Yes If yes, who referred you to camp? _____________________________

Name of Residential Facility or Agency (If applicable) ____

Agency Contact: _________________________ Office (____)______________ Cell (____)____________

Address ______________________________ City ____________________ State _____ Zip _____________

Email address: ____

Parent/Guardian _____________________________ Home Phone (____)__________ Cell (____)_________
Address ______________________________ City _____________________ State _____ Zip ______________
Email address:____
Where should program correspondence be sent? ☐Self (Camper) ☐Guardian ☐Agency Listed Above
☐Mail ☐Email

Additional Emergency Contacts:
1. NAME:_______________________________ Relationship to Camper:_________________
Day Phone: (___) __________________ Evening Phone: (____) __________________

2. NAME:_______________________________ Relationship to Camper:_________________
Day Phone: (_____) ___________________ Evening Phone: (___)________________

For emergency purposes, ALL Campers MUST complete this section.
Medical Assistance Number: ____
Insurance Carrier: __________________________________Policy Number: ________________________
Primary Medical Doctor________________________ Phone___________________________________

<u>MEDICAL CARE:</u>
☐I have a medical concern regarding camp and wish to be contacted by one of the nurses.

Height: ___________ Weight: ___________
Primary diagnosis: ____
Secondary diagnosis: ____
Cognitive ability/developmental delay**:** ☐Mild ☐Moderate ☐Severe developmental delay

Allergies: ☐None ☐Food ☐Drug ☐Environmental ☐Other
List & describe reaction:____

Seizure disorders:
☐No seizures ☐Seizures, Description:____
Seizure frequency: ___________________________________Date of last seizure: __________________
At what point do we call EMS for seizure related activity? ____
Does someone need to be contacted if camper has a seizure?__________________________

Diabetes: Is the camper diabetic? ☐Yes ☐No Normal blood sugar range: _______________
How frequently must blood sugars be checked at camp?_____________________

Other Health History:

☐ADD/ADHD
☐Asthma
☐Chronic or recurring illness
☐CHF
☐COPD
☐ Constipation
☐Shortness of breath
☐Bleeding/clotting disorders
☐Heart problems (heart failure, abnormal rhythm, blood pressure)
☐Heat related problems (camp has no air conditioning)
☐High Blood pressure
☐Joint problems

☐Psychiatric treatment
☐Recent surgery
☐Skin disorder
☐Stomach problems

Other:

☐Use a CPAP or BIPAP?
☐ Smoke? Type? Is there a schedule? Who manages?
☐Wear Glasses
☐Wear Dentures

Explain:
____
____

Medications:
Does the camper take medications? ☐Yes ☐No
All medications must now be bubblepacked as indicated on the attached flier:

☐I understand the new medication bubble pack guidelines and will have no trouble complying
☐I am confused by the new bubble pack guidelines and wish to be contacted by the nurse
☐ It will be difficult for me to obtain bubble packs and wish to be contacted by the nurse

Please attach copy of current med list. We realize it may change, but this aids preparations!

Do meds to be crushed? ☐No ☐Yes Applesauce/pudding***?*** ☐No ☐Yes (please send)

Permission to use over the counter medication:

☐Yes ☐No Tylenol	☐Yes ☐No Cough syrup
☐Yes ☐No Aspirin	☐Yes ☐No Antibiotic Ointment
☐Yes ☐No Ibuprofen	☐Yes ☐No Stool Softener
☐Yes ☐No Benadryl	☐Yes ☐No TUMS/Rolaids
☐Yes ☐No Hydrocortisone Ointment	☐Yes ☐No Pepto-Bismol

*please provide administration instructions if different from OTC label instructions

If the camper frequently experiences any of the following, please check the box and describe how these are best treated.

☐Nausea	☐Nightmares
☐ Diarrhea	☐ Stomach aches
☐ Dizziness	☐Headaches
☐ Over fatigue	☐Homesickness
☐Earaches	☐Constipation

Any additional information: ____

RELIGIOUS BACKGROUND:
Church Affiliation: ▢WELS ▢ ELS ▢Other: ________________________________
Name of Church: _________________________________ Pastor's Name: _____________________
Is Camper Baptized: ▢Yes ▢No Is Camper Confirmed: ▢Yes ▢No
Does Camper attend Church services regularly? ▢Yes ▢No
Does/has Camper attend religious instruction class? ▢Yes ▢No
If yes, please describe type (Sunday School, Confirmation Class, Bible Study, etc.)
____

MOBILITY:
Can the camper walk: ▢Unaided ▢With Physical Assistance ▢Walker/Cane
Uses braces or AFOs: ▢ No ▢Yes: Right/Left/Both
Walking speed: ▢Slow ▢Medium ▢Fast
Wheelchair needed for long distances? ▢No ▢Yes- please bring. Camp does not have paved walkways. Use is difficult)
Any additional information: ____

SPEECH & COMMUNICATION:
▢ Verbal ▢ Non-verbal Able to read? ▢ Yes ▢ No Able to write? ▢Yes ▢ No
If speech is severely limited, how does the camper communicate?__________________________________
Commonly used signs/gestures:____

PERSONAL HYGIENE
▢Showers Independently ▢Needs verbal cues ▢Needs total assistance showering
Needs assistance with: ▢Shampooing hair ▢Washing body ▢Adjusting water temperature ▢Brushing Teeth
Comments:____

DRESSING:
▢ Dresses/undresses independently ▢Needs partial assistance ▢ Needs total assistance
Can put on: ▢Underwear ▢Socks ▢Shirt ▢Pants Can: ▢Button ▢Snap ▢Zip ▢Tie shoes
Comments:____

SLEEP PATTERNS:
Sleeps through night: ▢Yes ▢No, explain____
Can the camper climb a ladder and sleep on a top bunk (with rail)? ▢Yes ▢No

BATHROOM USE:
▢ Uses toilet independently ▢Needs reminders ▢Needs help wiping
▢Uses incontinent briefs ▢All day ▢ Nights only
Men only: ▢ Sits to urinate ▢ Stands to urinate
▢Has toileting schedule. Explain schedule:____
How does he/she communicate when they need to use the restroom? __________________________
Comments:____

BEHAVIOR
Level of Supervision Required for Time at Camp (Please check only one)
▢Can function independently and in a group with little supervision
▢Needs some supervision, functions in a group of 2-4
▢ Benefits from one-to-one supervision throughout the day
Further explanation or comments:____
Activity Level:
▢ Has typical attention span for his/her age [or] ▢ Has a short attention span/ is easily distracted
▢ Is under active (needs motivation to participate) [or] ▢ Is overactive (needs help calming to participate)
Please describe how you manage his/her activity level, encourage him/her to participate, etc.
____

BEHAVIOR	NEVER	SELDOM	OFTEN	EXPLAIN/DETAILS
Stubborn	☐	☐	☐	______________________
Self-Abusive	☐	☐	☐	______________________
Hits, scratches, pinches	☐	☐	☐	______________________
Uses inappropriate words	☐	☐	☐	______________________
Yelling/disruptive	☐	☐	☐	______________________
Prefers to be alone	☐	☐	☐	______________________

Describe approaches to be used with difficult behavior. (Camp staff are not specifically trained to deal with challenging behaviors. If this is an area of concern for an individual, please contact Camp Phillip.):
____
What typically triggers challenging behaviors? ______________________________
What are two or three effective rewards? ______________________________

Has the applicant ever been away from home: ☐ Yes ☐ No Is homesickness anticipated: ☐Yes ☐ No
If yes, how can we assist with the transition?______________________________

LEASURE TIME ACTIVITIES: (What does the camper do for fun at home or like best about camp?)
Hobbies/interests: ______________________________
What are some favorite outdoor activities? ______________________________
What are some favorite indoor activities? ______________________________

Does the camper enjoy: ☐row boats/canoe ☐fishing ☐sitting by the water
☐Crafts/coloring ☐Singing/dancing ☐Nature ☐Playground ☐Outdoor games
☐ Puzzles ☐Reading ☐Board games_______________ ☐Card games_______________

Swimming: ☐ Independent ☐Uses life vest ☐Plays near edge
Doesn't swim but likes to: ☐ Dangles toes ☐ Observes others ☐Would not like being near water

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MEALTIME: *Staff will make every effort to adhere to diets. However, they may not be able to keep strict reducing diets. If there are special requirements, please send food with camper.*
Diet:______________________________
May the camper deviate from their diet, or portions of it, during camp? ☐Yes ☐No
If yes, specify: ______________________________
Consistency: **Solids:** ☐Regular ☐Pureed **Liquids:** ☐Thin ☐Thickened *please provide thickener
Does the camper use special cup/utensils? ☐Yes ☐No (If yes, please send)
Food likes:______________________________
Food dislikes: ______________________________
☐ Eats independently ☐Needs food cut ☐Needs total assistance
☐Has difficulty with choking or swallowing______________________________
Appetite: ☐Large ☐Medium ☐Small
May the camper have seconds within reason? ☐Yes ☐No
May the camper drink coffee? ☐Regular ☐Decaf Cup limit? ______________________________
(Camp only serves coffee during breakfast hours)

RELEASES TO BE SIGNED BY THE CAMPER'S GUARDIAN
Releases **must be signed** by the camper's guardian (or the camper if they are their own guardian). If the releases are not signed, the camper will not be permitted to attend camp.

PERMISSION TO ATTEND JESUS CARES CAMP PHILLIP
Camper name: ____
I grant permission for my son/daughter/ward to attend Jesus Cares Camp Phillip. I also give permission for Camp staff to dispense medication to my Camper as detailed in the Camper Registration Packet or communicated to them at the time of the Camper's arrival Jesus Cares Camp Phillip. I understand that there are not licensed and trained medical professionals on staff at Jesus Cares Camp Phillip.
Signature (parent or guardian):____
Printed:______________________________________ Date: _________________

AUTHORIZATION FOR TREATMENT / RELEASE OF LIABILITY
Camper name: ____
To the best of my knowledge, the health information is correct and complete. The person herein described has permission to engage in all camp activities, unless noted otherwise. Authorization for Treatment: I hereby give permission to the medical personnel selected by Jesus Cares Camp Phillip to order X-rays, routine tests, treatment, to release any records necessary for insurance purposes, and to provide or arrange necessary related transportation for me or the camper. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Jesus Cares Camp Phillip to secure and administer treatment, including hospitalization, for the person named above.

While camp staff strives to reduce risks to participants, accidents can and do occur. I understand there is risk in retreat activities that are beyond Jesus Cares Camp Phillip control. (In view of the current legal atmosphere, we must inform you that potential accidents in retreat programs may include, but may not be limited to: blisters, insect stings, sunburn, sprains, cuts, bruises, dislocations, fractures, concussion, spinal cord damage or even death) I agree to personally assume such risks and release JCM or Camp Phillip or other agencies from all liability for injury sustained during the retreat.
Signature (parent or guardian):____
Printed:__________________________________ Date: ___________________

PHOTO / PUBLIC RELATIONS CONSENT AND RELEASE
I understand that Jesus Cares Ministries and Jesus Cares Camp Phillip may wish to use my/my camper's name, photograph and/or stories with its work and that it needs appropriate consent to do so. Pictures may be taken for the purpose of sharing with the group, for sharing with area churches, the community and on the JCM web page. I hereby give my permission to Jesus Cares Camp Phillip to use for volunteer recruitment, fundraising and other communications purposes, photographs, films or audio recordings concerning myself/my camper. I hereby warrant that I have the full power to give this consent to sign this release.
Camper name: ______________________________
Signature (parent or guardian):____
Printed:__________________________________ Date: _________________

CAMP PHYSICAL EXAM

To be completed by a healthcare professional.

Camper name: ____Date of Exam ___________________

Provider name ____ Phone ______________________________

Height_________Weight_________BP_________P_________T_________R_________

1. In my opinion the camp applicant's condition (circle one) **WOULD / WOULD NOT** allow for his/her participation in an active camp program. (Campers will be staying in cabins with no air conditioning)

2. Primary medical diagnoses: ____

3. Allergies: ____

4. Does applicant have seizure disorders? ☐Yes ☐No

Type/Treatment____

5. Diabetes? ☐Yes ☐No Glucose checks at camp? ☐Yes ☐No Frequency/Instructions

____

6. Dietary restrictions while at camp ____

Any conditions related to:	History of:
Eyes	Asthma
Ears	Recent Illness
Throat	Kidney Disease
Skin	Stomach Disorders
Heart	Heart Disease
Lungs	Previous Surgery
Extremities	Psychiatric Illness
Abdomen	Blood/Clotting Disorder
Neurologic	

7. Any Further recommendations:

EXAMINER'S NAME___________________________**SIGNATURE** _____________________________