



CAMP DREAM

Camper Application

May 29th - June 1st 2003

Must be fully completed before camper is confirmed

PLEASE PRINT OR TYPE:

Social Security Number: _____ Date of Birth _____

I. IDENTIFYING INFORMATION

Last Name _____ First Name _____ Name Called _____ Sex _____ Age _____

Camper's Address _____ County _____

City _____ State _____ Zip _____ Home Phone _____ Email _____

Custody Status (please check) Independent _____ Parent _____ Other _____

Parent/Guardian Name _____ Address _____

City _____ State _____ Zip _____

Day Phone _____ Night Phone _____ Beeper # _____

Emergency contact other than above that can provide care for camper:

Parent/Guardian Name _____ Address _____

City _____ State _____ Zip _____

Day Phone _____ Night Phone _____ Beeper # _____

How did you learn about Camp Dream? _____

Can the camper swim? _____ Assistive Devices Needed _____

Level; Beginner _____ Advanced Beginner _____ Intermediate _____ Advanced _____

Has camper ever camped before? _____ Where? _____ When? _____

Has the Camper ever been on a boat or canoe of any kind? _____

What size T-shirt does the camper wear? _____

II. NATURE OF DISABILITY (please check all applicable)

- | | | |
|--|---|---|
| <input type="checkbox"/> Cerebral Palsy (wheelchair) | <input type="checkbox"/> Hearing impaired | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Cerebral Palsy (walks) | <input type="checkbox"/> Asthma | <input type="checkbox"/> Spinal Cord (quadriplegic) |
| <input type="checkbox"/> Spin Bifid (wheelchair) | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Spina Bifida (walks) | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Visually impaired |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemiplegia | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Spinal Cord (paraplegic) | <input type="checkbox"/> Autism | <input type="checkbox"/> Others _____ |
-

MENTALFUNCTIONING (check one):

- | | | |
|---|---|---|
| <input type="checkbox"/> Normal Function | <input type="checkbox"/> Learning Disabled | <input type="checkbox"/> Severely mentally challenged |
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Mildly mentally challenged | <input type="checkbox"/> Profound mentally challenged |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Moderately mentally challenged | |
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III. PERSONAL HISTORY

To be completed by parent/guardian or adult applicant. Indicate required assistance or level of involvement.

Height _____ Weight _____

Approximate mental age level _____ Approximate functional age level _____

EATING:

- No assist
 Partial assist
 Total assist
-

DIET:

- | | |
|---|--|
| <input type="checkbox"/> Normal | <input type="checkbox"/> If diabetic, total number of calories _____ |
| <input type="checkbox"/> Chopped food | <input type="checkbox"/> Low Cholesterol |
| <input type="checkbox"/> Blended/Pureed | <input type="checkbox"/> Low-fat |
| <input type="checkbox"/> Low Salt | <input type="checkbox"/> Any other special diet _____ |
| <input type="checkbox"/> Low Calorie | <input type="checkbox"/> Does camper have any difficulty swallowing? YES _____ NO _____ |
| <input type="checkbox"/> Diabetic | List problem foods or food allergies _____ |
- Note: Camper must bring adaptive aids for feeding.**
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HEARING:

- Normal
 Hearing Impaired
 Total loss

SPEECH:

- _____ Normal
- _____ Mildly affected
- _____ Moderately affected
- _____ Severely affected
- _____ Few words
- _____ Nonverbal

COMMUNICATION:

- _____ Normal
- _____ Sign language
- _____ Communication board
- _____ Gestures
- _____ Other

VISION:

- _____ Normal
- _____ Legally blind
- _____ Total loss
- _____ Impaired vision

MOBIL:

- _____ Walks
- _____ Cane
- _____ Crutches
- _____ Walker
- Wheelchair: ___ Manual ___ Electric)
- _____ Stretcher
- _____ Other

DOES CAMPER INDEPENDENTLY OPERATE WHEEL-CHAIR? _____ YES _____ NO

TRANSFERS:

- _____ Independent _____ Moderate assist
- _____ Standby _____ Maximum assist

ADAPT. DEVICES:

- _____ None
- _____ AFO's or Night Braces

- _____ Prosthesis
- _____ Helmet
- _____ Glasses
- _____ Hearing Aid
- _____ Dentures
- _____ Shunt
- _____ Other

TOILETING:

- _____ No assist
- _____ Partial assist
- _____ Total assist

Bladder control:

- _____ Normal
- _____ Incontinent
- _____ Needs reminders

Bowel control:

- _____ Normal
- _____ Partial
- _____ Incontinent

Needs reminders Aids used:

- _____ None
- _____ Urinal
- _____ Toilet chair
- _____ Diapers
- _____ Bedpan
- Catheter (___ Indwelling ___ Condom)
- _____ Ostomy (Ex: Colostomy)
- _____ Suppositories
- _____ Enema
- _____ Other

List toileting schedule

Note: Must bring all supplies needed.

WASHING/BATHING:

_____ No assist
_____ Partial assist
_____ Total assist

DRESSING:

_____ No assist
_____ Partial assist
_____ Total assist

SLEEPING:

Sleepwalk? _____ YES _____ NO
Need to be awakened or turned during night? ? _____ YES
NO
Can camper sleep on an upper bunk? _____ YES
NO

IV. Insurance Coverage for illnesses while participating in programs at Camp Dream is the responsibility of the camper and/or his/her family.

Please list your family health/accident, medical/hospital insurance coverage.

CARRIER _____
POLICY OR GROUP NO _____
MEDICARE NO _____
MEDICAID NO _____

V. MEDICAL INFORMATION - Every Blank Must Be Completed

List all allergies (if no allergies, please write "None") _____

Has camper had any recent hospitalizations/illnesses/communicable disease? _____ YES _____ NO

If yes, please explain:
?_

Can camper take Tylenol? _____ YES _____ NO

MEDICATIONS:

Please list all medication, dosages, and times medication is to be taken. Medications will be administered exactly as written below. Please be accurate and complete. You must provide all medications for your child. All medication must arrive in original container with the prescription label intact and legible. (If no medications are taken, please write "none".)

Name of Medication

Dosage

Times to be Taken

1. _____
2. _____
3. _____
4. _____
5. _____

List any further medications on a separate sheet please.

List all immunizations to present date

Please list any problems of which we should be aware:

Medical:

Behavioral:

Other:

Application Deadline is April 1st, 2003

Mail application with check to:

Pam Frost
711 Trickum Valley Drive
Woodstock, GA 30188
(770) 924-8553

Note: If camper is not accepted, a full refund will be made.

I hereby certify that all information given is true and complete.

Parent or Guardian Signature _____ Date _____

FOR OFFICE USE ONLY

_____ Date rec'd
_____ Approved
_____ Confirmation sent

_____ Amt. fee rec'd
_____ Date rec'd
_____ Paid by