

# Camper Application Form

CAMP ALLEN  
56 Camp Allen Road Phone: 603-622-8471  
Bedford, NH 03110-6606 FAX: 603-626-4295



**CAMP ALLEN**  
*Discovering abilities since 1931*

For more information contact:  
Mary C. Constance, Executive Director

## COSTS

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OVERNIGHT CAMP	DAY CAMP	EXCEPTIONS
1 week session = \$775.00	\$400.00 per week	Physical Challenges = \$1,750.00
2 Week Session = \$1,550.00	1:1 \$175.00 per week	1:1 week = \$1,050.00
1:1 Additional \$275.00 per week		All Star = \$775

## HOW TO APPLY

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1. Complete the requested information in each section carefully and completely.
  - Sections 1-18 should be completed by a parent, guardian or advocate.
  - The Camp Allen *Health Forms*, must be completed by a licensed physician **on our forms only**.
2. Include a recent photograph of the applicant to assist camp staff in identifying campers for medications and for security purposes.
3. Return the application to Camp Allen, 56 Camp Road, Bedford, NH 03110-6606

## ADDITIONAL INFORMATION

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- Camp is available on a first come first served basis. Acceptance into camp is contingent upon evaluation of a **complete** application by the camp director and medical advisors.
- Campers must meet our medical requirements and be able to live in an outdoor environment with a 1:2 staff to camper ratio. We are unable to make conditional offers.
- Campers are not enrolled until they receive an **acceptance packet** confirming a specific session.
- **If a camper is sent home due to medical reasons determined by the Camp Health Director, the camp fee will be prorated and a refund will be made. If the camper does not wish to remain at camp or if the camper is sent home due to behavioral issues, Camp Management reserves the right to determine whether or not a refund will be granted.**
- In order to best meet the needs of the camper, please submit any behavior plans or IEP's with this application.
- All medications must come through packaged according to our medication policy. Rapps pharmacy is the company we use for this process.
- Camp Management will to the best of our ability meet the camper's session date preference. However, the session dates are not guaranteed and the Camp Management reserves the right to enroll the camper into any appropriate session.
- Transportation to and from camp is the responsibility of the camper.

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## SECTION 1: SESSION PREFERENCE 2010 Dates

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### Overnight Camp

- Life Camp: May 23—May 29: For Young Adults Interested in Learning About Independent Living  
Training week for all staff: June 6—12
- Session 1: June 13—18: One to One! Adults Requiring More Supervision
- Session 2: June 20—July 1: Rock n Rollers. Longtimers With Physical Challenges
- Session 3: July 4—9: Kids and Young Folks
- Session 4: July 11—16: Rock n Rollers. MDA Week
- Session 5: July 18—29: All are Welcome
- Session 6: August 1—12: All Are Welcome! Young and Young at Heart
- Session 7: August 15—20: All Are Welcome! Young and Young at Heart
- Session 8: August 22—27: All Star. Field Trips and Sports

### Day Camp

- Session 1: June 21—25
- Session 2: June 28—July 2
- Session 3: July 5—9
- Session 4: July 12—16
- Session 5: July 19—23
- Session 6: July 26—30
- Session 7: August 2—6
- Session 8: August 9—13
- Session 9: August 16—20

## SECTION 2: PERSONAL INFORMATION

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Camper Name \_\_\_\_\_ Parent/Caregiver Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

Have you attended Camp Allen before?  Yes  No Year(s) \_\_\_\_\_

1:1 Required  Behavioral  Physical Assistance  No 1:1 Needed  Please Call, I am Unsure

**Disability** (Check all that apply)  Cerebral Palsy  Aspergers Syndrome  Mental Retardation  Autism

Down Syndrome  Traumatic Brain Injury

Other (Please specify) \_\_\_\_\_

**Camper Lives** (Check one)

Family Care Home  At home  Other \_\_\_\_\_

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## SECTION 2: PERSONAL INFORMATION Continued

Ethnic Information (Please check one)

African American    Native American Asian    Caucasian    Latino/Mexian American    Other \_\_\_\_\_

Person Completing this Application \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

\_\_\_\_\_ Other Number \_\_\_\_\_

Email \_\_\_\_\_ Fax Number \_\_\_\_\_

Service Coordinator \_\_\_\_\_ Phone Number \_\_\_\_\_

Email \_\_\_\_\_

**Emergency Contact 1** Parent(s) or legal guardian(s) must be available in case of emergency.

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

\_\_\_\_\_ Other Number \_\_\_\_\_

Email \_\_\_\_\_

**Emergency Contact 2** Parent(s) or legal guardian(s) must be available in case of emergency.

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

\_\_\_\_\_ Other Number \_\_\_\_\_

Email \_\_\_\_\_

## SECTION 3: INSURANCE INFORMATION

Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

Other Company \_\_\_\_\_ Number # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_

Social Security Number \_\_\_\_\_ Subscriber Number \_\_\_\_\_

Insurance Address \_\_\_\_\_ Group Number \_\_\_\_\_

## SECTION 4: PHYSICIAN INFORMATION

Primary Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Physician Address \_\_\_\_\_

\_\_\_\_\_

Other Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Physicians Address \_\_\_\_\_

\_\_\_\_\_

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## SECTION 5: CONSENT TO TREAT

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I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatments for myself/applicant. I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for myself/applicant as named in application.

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Parent/Guardian/Advocate Signature

Date

**If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.**

The applicant/guardian has read and understands all the information in this application. The applicant will receive a Health and Medical Exam form that must be completed and returned before they will be admitted to Camp Allen.

The applicant must have a written physician release to attend Camp Allen if they have been recently exposed to a contagious disease within the three weeks prior to coming to camp, or if they have had a major change in medical condition in the prior year.

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Parent/Guardian/Advocate Signature

Date

## SECTION 6: CONSENT TO ATTEND AND PARTICIPATE

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As Parent/Guardian/Advocate, I give permission for \_\_\_\_\_ to attend Camp Allen and participate in all activities. I also agree not to send this person to Camp Allen if exposed to a contagious disease within 21 days of the date the applicant is to arrive at Camp Allen.

The applicant agrees to engage in all camp activities including fieldtrips and bus trips off the camp property.

The applicant agrees to release any claim or cause of action which may accrue against Camp Allen and any employee of Camp Allen and any person acting with the permission of Camp Allen, arising out of injury to the camper during stay at camp, in transit to or from Camp, or during an activity by any of said persons, and the applicant/guardian agrees to assume claim which said minor in their personal capacity might have against any of said persons for injury herein stated.

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Parent/Guardian/Advocate Signature

Date

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## SECTION 7: CAMPER RELEASE INFORMATION

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Please list individuals granted permission to pick up the camper at any time during the campers session.

Camp management will release the camper only to individuals listed below.

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

\_\_\_\_\_ Other Number \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

\_\_\_\_\_ Other Number \_\_\_\_\_

## SECTION 8: GENERAL MEDICAL INFORMATION

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Does the camper have a seizure disorder?  Yes  No

If yes, describe how often, type, duration, characteristic, etc. \_\_\_\_\_

Does the camper have a history of skin breakdown?  Yes  No

If yes, describe the history of skin breakdown and list preventive techniques. \_\_\_\_\_

Orthopedic appliances and equipment. (Check all that apply)

Right Leg  Left Leg  Trunk  Corset  Right Hand  Left Hand  Helmet

Other (Please specify) \_\_\_\_\_

Orthopedic appliances and equipment schedule \_\_\_\_\_

Is the camper  Ambulatory  Non-ambulatory

**If ambulatory**, can the camper walk independently?  Yes  No

Does the camper ever use a walker or a wheelchair?  Yes  No

If yes, please specify \_\_\_\_\_

**If non-ambulatory**, what type of chair will the camper bring to camp?  Manual  Electric

If manual, can the camper self-propel?  Yes  No

How does the camper communicate? \_\_\_\_\_

Any Psycho-social issues? \_\_\_\_\_

How Does the camper take medication? \_\_\_\_\_

Has the camper ever refused Medication?  Yes  No

**If the camper refuses medication you will be called after the first incident for consultation. Understand that it may be necessary to send a camper home who refuses medication.**

## SECTION 8: GENERAL MEDICAL INFORMATION Continued

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Will the camper bring any communication equipment/devices to camp? \_\_\_\_\_

How else does the camper make his or her needs known? \_\_\_\_\_

## SECTION 9: BEHAVIORS

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In order to provide a safe camping experience for the campers and staff, please include a behavior plan if one has been written. Please check all that apply.

Self-abuse  Yes  No Details \_\_\_\_\_

PICA  Yes  No Details \_\_\_\_\_

Wandering  Yes  No Details \_\_\_\_\_

Physically abusive  Yes  No Details \_\_\_\_\_

Sensitive to touch  Yes  No Details \_\_\_\_\_

Emotional outbreaks  Yes  No Details \_\_\_\_\_

Verbally abusive  Yes  No Details \_\_\_\_\_

Lying  Yes  No Details \_\_\_\_\_

Stealing  Yes  No Details \_\_\_\_\_

Self-stimulating  Yes  No Details \_\_\_\_\_

Temper tantrums  Yes  No Details \_\_\_\_\_

Other behaviors \_\_\_\_\_

How does the camper react when upset, homesick or frustrated? \_\_\_\_\_

\_\_\_\_\_

What methods should be used to manage these behaviors? \_\_\_\_\_

\_\_\_\_\_

**Failure to disclose information will result in camper being sent home and loss of tuition. Please give Camp Allen as much information as possible in order to properly care for your camper. Physical, sexual and verbal aggression towards others can not be tolerated.**

## SECTION 10: CAMPING AND LEISURE INTERESTS

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List previous camping experiences (Day/Overnight) \_\_\_\_\_

Did the camper enjoy the experience(s) and adjust well? \_\_\_\_\_

What were the camper's favorite things about camp? \_\_\_\_\_

## SECTION 11: ACTIVITIES OF DAILY LIVING

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Please review all the activities of daily living listed and provide details about the assistance the camper will require.

Help eating?  Yes  No Details \_\_\_\_\_

Help grooming?  Yes  No Details \_\_\_\_\_

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## SECTION 11: ACTIVITIES OF DAILY LIVING Continued

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Help dressing?  Yes  No Details \_\_\_\_\_

Help bathing?  Yes  No Details \_\_\_\_\_

Help toileting?  Yes  No Details \_\_\_\_\_

What is the word or method of toilet indication? \_\_\_\_\_

Wears diapers (Attends)?  Night  Day  Both Details \_\_\_\_\_

Females. Help with menstruation cycle?  Yes  No Details \_\_\_\_\_

What are the camper's normal sleeping hours? \_\_\_\_\_

Has the camper been known to sleepwalk?  Yes  No Details \_\_\_\_\_

Does the camper require bed rails?  Yes  No Details \_\_\_\_\_

Does the camper wet the bed?  Yes  No Details \_\_\_\_\_

Does the camper generally sleep well?  Yes  No Details \_\_\_\_\_

**Please note: We do not provide awake overnight staff. Two staff members sleep in each cabin nightly and are responsible for routine bathroom trips and assistance. We cannot accommodate campers who require consistent and frequent assistance throughout the night.**

## SECTION 12: ADDITIONAL INFORMATION

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Does the camper have any strong fears (e.g. darkness, water, thunder, bugs)? \_\_\_\_\_

Is there any further information that may be helpful in understanding the camper and his or her needs at camp? \_\_\_\_\_

Is there any additional assistance the camper may require while at camp? \_\_\_\_\_

## SECTION 13: MEDICATION AND AUTHORIZATION

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Check one.  \_\_\_\_\_ takes no medication.

Camper Name

I authorize administration of the prescribed medications by Camp Allen.

\_\_\_\_\_  
Parent/Guardian/Advocate Signature

\_\_\_\_\_  
Date

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## SECTION 14: SWIMMING PERMISSION FORM

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Camper Name \_\_\_\_\_

What level swimmer is he/she? Please check the appropriate box.

- No experience (has never swam before)  
 Beginner (has swam before)  
 Experienced (can swim without flotation support)

What type of adaptive equipment does he/she wear in the pool? \_\_\_\_\_  
\_\_\_\_\_

Are there any swimming restrictions?  Yes  No Explain \_\_\_\_\_  
\_\_\_\_\_

I give the above named camper permission to swim at Camp Allen.

\_\_\_\_\_  
Parent/Guardian/Advocate Signature

\_\_\_\_\_  
Date

**Please note: Swimmers have to complete a swim test in order to be in the pool without a lifejacket.**

## SECTION 15: PHOTO RELEASE FORM

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Camper Name \_\_\_\_\_

Please check the appropriate box(s)

- Permission is given to Camp Allen to use any photograph and video taping of the applicant and the applicant's name for television, news stories, newspaper articles, news releases, publications (brochures, newsletters, website, etc.) and community awareness programs and campaigns.
- Permission is given to Camp Allen to take pictures of the applicant to be used only for staff's Facebook/Myspace and other internet pages.
- Permission is given to Camp Allen to take pictures of the applicant to be used only for staff's personal enjoyment (memories).
- Please, no photos.

\_\_\_\_\_  
Parent/Guardian/Advocate Signature

\_\_\_\_\_  
Date

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## SECTION 16: TRANSFER/POSITIONING/MOBILITY FACT SHEET

Camper Name \_\_\_\_\_

This individual requires the following assistance with transfers.

**Mechanical Lift**

**Two-person Lift** – (unable to bear weight or assist with transfer).

Please list suggestions for lifting. \_\_\_\_\_

Does Camp Allen need specific training?  Yes  No

Training by the person bringing the camper on transfers/lifts.

### Wheelchair Information

Wheelchair serial# \_\_\_\_\_

Vendor providing service \_\_\_\_\_ Service Vendor's phone \_\_\_\_\_

### Wheelchair Mobility

Manual w/c  Power w/c  Walker/Braces

\_\_\_\_\_ Propels forward

\_\_\_\_\_ Maneuvers around objects

\_\_\_\_\_ Negotiates ramps

\_\_\_\_\_ Lateral weight-shift in w/c

\_\_\_\_\_ Propels backward

Endurance (distance/time) \_\_\_\_\_

Method of propulsion \_\_\_\_\_

### Ambulation

Assistive/Protective Device \_\_\_\_\_

Endurance (distance/time) \_\_\_\_\_

\_\_\_\_\_ level surfaces

\_\_\_\_\_ uneven surfaces

\_\_\_\_\_ stairs/curbs

\_\_\_\_\_ inclines

### Communication (Please check all that apply)

Verbal  Sign Language  Gesture  Language Board  Other \_\_\_\_\_

## SECTION 17: DINING FACTS SHEET

Name \_\_\_\_\_ Med Precautions \_\_\_\_\_

Food Allergies \_\_\_\_\_ Special Diet \_\_\_\_\_

## SECTION 17: DINING FACTS SHEET Continued

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### This individual requires the following assistance with dining:

- High Need** – Requires ongoing assessment and monitoring due to health concerns and swallowing disorder.
- Consistent** – Requires continuous monitoring from staff familiar with individual dining plan.
- General** – Requires physical presentation of food ; no direct therapeutic intervention needed.
- Supervised** – Requires assistance set-up, cut-up and or clean-up.
- Independent** – Requires no supervision during dining.

### MEAL SET-UP

#### FOOD

##### Consistency

- Pureed
- Ground
- Chopped 1/4 x 1/4
- Chopped 1/2 x 1/2
- Regular

##### Adaptive Equipment

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PLEASE  
PLACE PHOTO  
HERE.

#### BEVERAGE

##### Consistency

- Thin Liquid
- Thickened Liquid
- Nectar
- Honey
- Pudding

##### Adaptive Equipment

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##### Amount

- Single Sip
- 2, 3, 4 Consecutive Sips
- Spoon Fed
- Other \_\_\_\_\_

### POSITIONING/OT NEEDS

Note the positioning for the individuals and dining assistant.

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**INDIVIDUAL DINING PLAN** (i.e., placement of food, rate, prompting, dry spooning, routine after meal, etc.)

### OTHER

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### FOOD/LIQUID CONSISTENCY GUIDELINES

All consistency recommendations are based upon the needs of the individual.

## SECTION 18: WAIVER

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All the information provided in this application is accurate and complete to the best of my knowledge.

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Parent/Guardian/Advocate Signature

Date

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### Camp Allen Refund Policy

Prior to May 1, the deposit less a \$100.00 registration fee will be returned. For cancellation after May 1, no refund of deposit will be made unless the campers' slot is filled. If the camper departs early from camp for medical reasons, a prorated refund based on the number of days at camp will be made. If a camper departs from camp for behavioral reasons, refusing medication or if the camper was placed in an inappropriate session because of inaccurate camper care information **NO** refund will be made.