Advocacy and Services for People with Disabilities
Oneida-Lewis Chapter NYSARC

Administrative Offices: 245 Genesee Street, Utica NY 13501

Kids' Camp Application

Camper's Name: ______________________________

DOB: ______________ Age: ______ Sex: ______ Telephone: ______________

Home Address: ______________________________ City: ______________

Primary Disability: ______________________________ If None Check Here ☐

Parent Name(s): ______________________________

Parent Daytime Phone Number(s): Home: ______________ Cell: ______________

Medicaid Service Coordinator's Name: ______________ Agency: ______________ Telephone: ______________

PLEASE CHECK WEEK(S) DESIRED ACCORDING TO PREFERENCE

	1st CHOICE	2nd CHOICE
WEEK 1 June 28 - July 2	☐	☐
WEEK 2 August 16 - 20	☐	☐

Requesting Transportation: Yes No

Children's Services
Shannon Clark
Children's Programs Coordinator
315.272.1588

CAMP APPLICATION

Are you requesting an Operation Sunshine Campership for your child? Yes No

1. Does the camper have any behavioral issues we may need to address? Explain. (Please include any warning signs):

2. Please circle the following disabilities /impairments that apply and note any assistance needed:
   Deafness Blindness Crutches/Braces Non-verbal Wheelchair
   Assistance Needed:

3. Will the camper need One-to-One Assistance in any of the following areas? (Please circle.)
   Toileting/incontinent Behavior Wandering Seizures Eating Changing clothes Other
   Please explain:

Any adaptive equipment that must be sent with the camper?

4. Does the camper have a fear of water? Animals? Other:

5. Please note any other information we should know about the camper:

MEDICAL INFORMATION

Does the camper have any allergies: Yes No

If yes, please specify the allergy and reaction:

Please fill out the following information regarding the camper's medication. Please be sure to indicate if the medication will need to be dispensed to the camper during camp hours. (Attach additional sheets if necessary.)

Name of Medication	Dosage	Time(s) of Day Taken	Prescribing M.D.	Does it need to be dispensed at Camp?

If medication is required at camp, a copy of the prescription must be sent with the medication(s) to camp. Any PRN medications must also be sent in, especially if taken for allergies.

1. Date of camper's last tetanus shot:

2. Note any special dietary needs/restrictions:

3. Does the camper have seizures/seizure-like activities? If yes, please describe:

4. Please list any other pertinent medical information you feel we should know about the camper:

EMERGENCY CONTACT INFORMATION

Physician: ____

Telephone: ____

Parent/Caretaker Name(s): ____

Telephone: ____

ADDITIONAL EMERGENCY CONTACT

Person: ____

Relationship to Camper: ______________________ Telephone: ______________________

PERMISSION

The following (4) areas MUST be completed and signed in order for the camper to attend camp.

1. I hereby Give Do Not Give
   my permission to allow the camper to participate in water games.

2. I hereby Give Do Not Give
   my permission to allow the above named camper to be photographed at camp and on field trips.

3. I hereby Give Do Not Give
   my permission for emergency medical treatment by camp staff and/or a physician in case of a medical emergency involving the above named camper. I also give permission for an ambulance to be called if necessary. I will be responsible for any expense arising from such an emergency.

4. I hereby Give Do Not Give
   my permission for the camper to participate in fishing at camp.

Parent/Guardian Signature:____Date:_____________________________

ATTACH CURRENT PHYSICAL AND OVER THE COUNTER MEDICATION PERMISSION SHEET OR
HAVE YOUR PHYSICIAN COMPLETE THE FOLLOWING INFORMATION.

Physical Form/Over the counter permission sheet for

1. Normal vital signs: Pulse Respiration B.P.
2. Cardiac Precautions:
3. Respiratory Precautions:
4. Gross Motor Exercise Limitations:
5. Limitations for Water Game Activities:
6. Physical activities: Please check if the activitiy should be limited, put "0" if the activity should be avoided:
   ____Walking ____Standing ____Stooping ____Kneeling ____Lifting
   ____Pushing ____Reaching ____Climbing ____Pulling
7. Please check conditions that should be limited, put "0" if the condition should be avoided:
   ____Outside ____Inside ____Humid ____Dusty ____Hot Weather ____Cold Weather
8. Special Diet Instructions:

OVER THE COUNTER MEDICATION PERMISSION

If you do not wish any of the below medications used, please eliminate it by drawing a line through that drug. Generic medications may be used unless you state otherwise. If you wish to make an addition, please do so and state dosage and time instructions for administration.

The camper may receive the following over-the-counter medications, as directed, for no longer that 48 consecutive hours, then the primary physician must be contacted. A parent/caregiver, registered nurse or doctor must be notified prior to administration of any oral medications if the staff has concerns about the individual's condition.

Parent Signature: ___________________________________

Date: ____

Physician/Nurse: ___________________________________

Signature: ____

Date: ____

Medications	**Administration Directions**
Children's liquid Acetaminophen Age 4-5yrs. 36 - 47lbs. - 1 1/2tsp. Age 6-8yrs. 48-50lbs. 2tsp. Age 9-10yrs. 60-71lbs. 2 1/2tsp. 11+yrs. 72-95lbs. 3tsp. or Acetaminophen 325mg. Tab as per label directions.	PRN for headaches, pain, elevated temperatures greater than 99 degrees. May also be given to females for menstral cramps.
Bacitracin, Betadine, Hydrohen Peroxide, A&D Ointment, Calamine Lotion, Desenex, Aloe Vera gel, Cortaid 1% cream with or with out aloe.	PRN to cuts, bruises, rashes, or minor burns according to the agency's First Aid Policies. DO NOT APPLY NEAR THE EYES.
Novahistine Elixir as per instructions on label NOT TO EXCEED 4 doses in a 24hr. peroid	PRN for nasal congestion from the common cold.
Pepto Bismol as per instructions on label. Up to a maximun of 6 doses in a 24hr. period.	PRN for stomach upset and/or diarrhea only when temperature is less than 99 degrees.
Robitussin DM as per instructions on label	PRN to relieve coughing due to common cold.
Sunscreen (#30 or above)	
Additions	

Parents/Caregivers – Please complete the following 4 questions:

1. Has the camper attended the Charles B. Wolken Memorial Day Camp in the past? Yes No

2. Is this the only vacation the camper will take this year? Yes No

3. Will the camper have a sibling joining him/her?

4. Have you completed another application for the sibling? Yes No

Parent / Caregiver Permission:

I hereby give / do not give (please circle one) my permission to allow the child / children named on this application to be photographed during the Kids' Camp Program sessions. I understand the photos may be used to promote the program.

I hereby give / do not give (please circle one) my permission for emergency medical treatment by staff and/or a physician in case of a medical emergency involving the child/children on this application. I also give permission for an ambulance to be called if necessary. I will be responsible for any expenses arising from such emergency.

____

Parent/caregiver's signature Date