Camp Hope: Child Camper Application

Is this Camper's first time applying to Camp Hope? ☐ Yes ☐ No				
Camper Name *(First, Middle, Last)*:				Nickname:
Gender: ☐ Male ☐ Female	Age:	Date of Birth:	Grade:	School:
Address:		City:	State:	Zip:
Camper Shirt Size *(select one)*: ☐ Youth Small ☐ Youth Medium ☐ Youth Large ☐ Youth X-Large ☐ Adult Small ☐ Adult Medium ☐ Adult Large ☐ Adult X-Large				
Child's Swim Level *(required)*: ☐ No Experience ☐ Beginner ☐ Intermediate ☐ Advanced				
Has your child ever attended a day camp? ☐ Yes ☐ No	Has your child ever attended an overnight camp? ☐ Yes ☐ No		Has your child spent the night away from home? ☐ Yes ☐ No	
Caregiver Name:			Relationship to Child:	
Daytime Phone:	Evening Phone:		Cell Phone:	
Email: *(Provide only if you use it regularly)*			☐ Check if you prefer texting	
Full Name of Deceased: *(The loss child will focus on at camp)*			Relationship to Child:	
Cause of death:			Date of death:	
Birthdate of deceased:	Age of deceased at death:		Age of child at time of death:	
What are some things the deceased liked to do? How did they spend their time? *Hobbies, Sports, Talents*				
Does your child **know the facts** about the cause of death? ☐ Yes ☐ No			Does your child **understand the facts** about cause of death? ☐ Yes ☐ No	

Has your child experienced other losses, deaths or trauma? ☐ Yes ☐ No

If yes, please include the name(s) and the relationship to the child and/or the circumstances of the loss.

Is English your child's primary language? ☐ Yes ☐ No If NO, the primary language? _________________________

Are there any cultural or religious needs that we should know about? ☐ Yes ☐ No

If YES, please describe:

How is your child responding to the loss? Coping well? ☐ Yes ☐ No

PLEASE EXPLAIN:

Are there behaviors or moods that concern you? ☐ Yes ☐ No

PLEASE EXPLAIN:

Please describe your child's personality (shy, outgoing, etc.)

Please describe activities your child enjoys:

What do you hope your child will gain by attending CAMP HOPE?

How did you hear about Camp Hope? Please check all that apply:

☐ Television
☐ Newspaper
☐ School
☐ Faith Community

☐ Funeral Home
☐ Community Event
☐ Website
☐ Family / Friend / Neighbor

☐ Hospice Staff / Volunteer
☐ Referral by list name and number
____
____

Getting to Know You

To be completed by camper with help from a grown up, if needed

PLEASE INCLUDE A RECENT PHOTO

The name I like to be called: ________________________________

Things I like to do ____

My favorite sport or activity ____

My favorite sports team ____

My favorite subject in school ____

My favorite board or card game ____

Let me tell you about my pet(s): ____

The farthest place I've traveled to is ____

If I could pick one place on earth to travel to, it would be ____

My best friend would tell you that I am ____

One thing I think I will like best about CAMP HOPE ____

Is there one thing that makes you nervous about coming to camp? ____

This is how excited I am about coming to camp: (Circle one)

1	2	3	4	5	6	7	8	9	10

Health History & Medical Healthcare Form

Basic Information

—To be completed by parent/caregiver or, with their permission, a school nurse or other adult —

HEALTH INSURANCE
In case of emergency it is vitally important that everyone in Camp be covered by Health and Accident Insurance. The Camp does not carry accident insurance on our campers. Any treatment expenses, which are not incurred because of the Camp's liability, MUST be covered by the camper's insurance or by the camper's parent or legal guardian. Campers are typically covered under family policies (i.e. BCBS, Independent Health, etc.), Group Insurance, or Medicaid.

Is the child covered by Family Health and Accident Insurance? ☐ Yes ☐ No

Name of Policy Holder:	Relationship to Child:
Health Insurance Carrier or Plan Name:	
Agent or Company:	Phone Number:
Policy or Certificate Number:	Group Number:

Please attach a photocopy of the front and back of the insurance cards.

INCLUDE PHOTOCOPY: **Back of Insurance Card**	**INCLUDE PHOTOCOPY:** **Back of Insurance Card**

AUTHORIZED EMERGENCY CONTACTS *We need to be able to locate you or an emergency contact at any time during the camp weekend. We will try to reach you first. Please provide information for two (2) emergency contacts and contact information for your child's physician and dentist or orthodontist.*

Contact Name #1:		Relationship to Child:	
Daytime Phone:	Evening Phone:	Cell Phone:	
Contact Name #2		Relationship to Child:	
Daytime Phone:	Evening Phone:	Cell Phone:	
Name of Child's Physician:		Phone:	
Address:	City:	State:	Zip:
Name of Child's Dentist / Orthodontist:		Phone:	
Address:	City:	State:	Zip:

Health History

To be completed by parent/caregiver or, with their permission, a school nurse or another adult

— AND —

Reviewed by licensed Health Care Professional

Has / Does the Camper:	**Y**	**N**	**Has / Does the Camper:**	**Y**	**N**
1. Had recent injury, illness, or infectious disease			15. Ever been diagnosed w/ a heart murmur		
2. Have a chronic or recurring illness / condition			16. Has/Had back problems		
3. Ever been hospitalized			17. Has/Had joint problems (knees, ankles, etc.)		
4. Ever had surgery			18. Has an orthodontic appliance		
5. Has frequent headaches			19. Has any skin problems (rash, acne, etc.)		
6. Ever had a head injury			20. Has diabetes		
7. Ever been knocked unconscious			21. Has asthma		
8. Wear glasses/contacts/ protective eyewear			22. Had mononucleosis in the past 12 months		
9. Has/Had frequent ear infections			23. Has problems with diarrhea / constipation		
10. Ever passed out during or after exercise			24. Has problems w/ sleepwalking		
11. Ever been dizzy during or after exercise			25. If female, has begun menstrual periods		
12. Ever had chest pain during or after exercise			26. Has a history of bed-wetting		
13. Ever had a seizure			27. Ever had an eating disorder		
14. Ever diagnosed w/ high blood pressure			28. Ever had emotional difficulties for which professional help was sought		

From list above… Note each "YES" item number and explain	
#	#
#	#
#	#
#	#

Restrictions:

Medication Allergies: ☐ Yes ☐ No *Please list:*	Describe reaction:	Describe management of the reaction:
Other Allergies *(list insect stings, hay fever, asthma, animal dander, etc.)*	Describe reaction:	Describe management of the reaction:
Food Allergies *(please list)*:	Describe reaction:	Describe management of the reaction:

Health History (Continued)

To be completed by parent/caregiver or, with their permission, a school nurse or another adult

— AND —

Reviewed by licensed Health Care Professional

THIS CHILD…	
☐ Does not eat red meat ☐ Does not eat poultry ☐ Does not eat pork ☐ Does not eat seafood ☐ Does not eat eggs ☐ Does not eat dairy products ☐ Does not eat nut products	☐ Other *(please describe):* ☐ Follows a medically-prescribed meal plan *(please describe):*
Please use this space to provide any additional information about the child's behavioral, physical, emotional, or mental health that may help the camp staff understand and provide for their needs:	
Please explain any PHYSICAL ACTIVITY RESTRICTIONS or LIMITATIONS:	

Pages 5 and 6 were completed by:

Signature: ____ Date: _____________

Printed Name: ____

Pages 5 and 6 were reviewed by Health Care Professional: *(complete below or provide stamp)*

Signature: ____ Date: _____________

Printed Name: ____

Medical Healthcare Form (Page 1 of 2)

— To be completed by a by licensed HEALTH CARE professional —

I examined *(child's name)*____ on *(date)* ____________________

In my opinion, the applicant: ☐ **IS** ☐ **IS NOT** able to participate in an active camp program.

Child's weight______________ Height__________________ BP___________________ Pulse___________________

The applicant is under the care of a physician for the following conditions:

1.

2.

3.

Which of the following has the camper had?	**Please give all dates of immunizations for: —OR— ☐ COPY ATTACHED**						
	VACCINE	**MO/YR**	**MO/YR**	**MO/YR**	**MO/YR**	**MO/YR**	**MO/YR**
☐ Measles	DTP						
☐ Chicken Pox	TD (tetanus/diphtheria)						
☐ German Measles	Tetanus						
☐ Mumps	Polio						
☐ Hepatitis A	MMR or						
☐ Hepatitis B	Measles						
☐ Hepatitis C	Mumps						
☐ **TB Mantoux Test**	Rubella						
Date of last test: ________________	Haemophilius Influenza B						
Result: ☐ POS ☐ NEG	Hepatitis B						
IF PPD POS: CXR: ☐ POS ☐ NEG	Varicella (Chicken Pox)						

All prescription medications for administration at camp:

- MUST be noted on this health form and given to the Camp Nurse during camp check in
- MUST be in the original prescription containers, clearly marked with the child's name, physician, name of medication, dosage, frequency of use
- ***MAY NOT be SHARED*** by more than one child in the same family
- SHOULD BE LIMITED to the amount of medication needed for the weekend
- SHOULD SPECIFY if the medication needs to be refrigerated

Please **CHECK ONE:**

☐ This CHILD takes **NO MEDICATIONS** on a routine basis

☐ This CHILD takes medications as follows: *(please list on page 8)*

Medical Healthcare Form (Page 2 of 2)

— To be completed by a by licensed HEALTH CARE professional —

Name of Child: ____ DOB: _______________________________

Please list ALL MEDICATIONS taken routinely (both RX and OTC medications): —OR— ☐ Form attached

Medication #1	Dosage:	Times taken each day:
Reason for taking:		
Medication #2	Dosage:	Times taken each day:
Reason for taking:		
Medication #3	Dosage:	Times taken each day:
Reason for taking:		
Medication #4	Dosage:	Times taken each day:
Reason for taking:		
Medication #4	Dosage:	Times taken each day:
Reason for taking:		

☐ EPI pen for anaphylactic shock / questionable reactions *(provided by parent/caregiver for use with prescription)*
☐ See attached for more medications

Identify any meds routinely taken during school that the participant does/may not take during the summer or weekends:

OVER THE COUNTER MEDICATIONS: I hereby authorize that the following medications may be given to the above named participant as the circumstances call for, unless otherwise noted.

Y	N	
		Ointment (antiseptic, anti-itch, anti-sting, antibiotic, sunburn) for minor wound care, first aid, etc.
		Tylenol for fever, pain, headache, etc. as directed on bottle for age/weight
		Ibuprofen for pain, headache, etc. as directed on bottle for age/weight
		Throat lozenges for sore throat
		Vitamin C supplement as needed
		Micatin or Anti-Fungus oil for athlete's foot
		Pepto Bismol for nausea or diarrhea as directed on bottle for age/weight
		Kaopectate for diarrhea as directed on bottle for age/weight
		M.O.M. laxative as directed on bottle for age and weight
		Mylanta for nausea as directed on bottle for age/weight
		Benadryl for swelling, hives, allergic reaction, as directed on bottle
		Medicaine Sting-Ease Swabs for insect stings
		Actifed or **Sudafed** for nasal congestion or allergy relief per bottle instructions
		Visine/Murine Plus for minor eye irritation
		Swimmers Ear Drops as per directed on bottle
		Hydrocortisone 0.5% for persistent rashes, poison ivy, and bug bites
		Robitussin Cough Syrup per bottle directions
		Calamine Lotion for bug bites and poison ivy
		Sunscreen SPF #30
		Insect Repellant

MEDICAL HEALTHCARE FORM *PAGES 7&8*	*Signature of Licensed Health Care Professional:*		OR PLACE STAMP HERE
	Printed Name:	Title:	
	Address:		
	Phone:	Date:	

Parent / Caregiver Authorizations:

By signing this form, I agree to the following conditions:

This health history is correct and complete as far as I know. The child described is a healthy person who is physically, mentally, socially, and emotionally capable of a camp experience. No participant shall be brought to camp if they are known to have any contagious conditions (pink eye, lice, etc.) My child has permission to fully engage in all camp activities, except as noted, subject to the policies, rules, and regulations of Camp Hope.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for my child.

In the event I, or AUTHORIZED emergency contacts, cannot be reached in an emergency, I hereby give permission to the Camp Coordinator or their designee, to act as the parent/caregiver concerning the health and welfare of the participant. I also give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for my child, named above.

As the parent/caregiver of the above-named child, I hereby waive, release, and forever discharge Niagara Hospice and its officers, agents, employees, representatives, executors, and all others acting on their behalf from any responsibility or liability for any injury or damage sustained resulting from the participant's use of the camp equipment or facilities or participation in camp activities, whether on camp premises or at another location. I understand the risks and dangers involved in participation in programs and activities of Camp Hope.

The camp has permission to use any photographic or audio materials produced during the camper's participation for the purposes of record keeping or promotion.

I understand Camp Hope retains the right to enforce its rules, and if necessary, will contact me or AUTHORIZED emergency contact(s) and send home, any camper infringing on the rights of others or whose behavior/actions are otherwise unacceptable.

Parent/Caregiver Signature:	Date:

Your child is not eligible for consideration for camp until we receive an application with health form COMPLETED IN FULL

Please return completed application to:

Mail: Camp Hope c/o Niagara Hospice, 4675 Sunset Drive, Lockport, NY 14094,

Email: CampHope@NiagaraHospice.com **Fax:** 716-439-6214