Athlete Registration
Camp Abilities Olympia
Information Packet Checklist

Parent Name(s)____

Camper name____

FORMS THAT NEED TO BE RETURNED NO LATER THAN SEPTEMBER 16, 2016. PLEASE EMAIL AS A PDF TO
Keithdavid17@msn.com

1 PAGE – PERMISSION SLIP

1 PAGE – CHILD INFORMATION SHEET

1 PAGE- RELEASE FORM

2 PAGES – WAIVER & LIABILITY FORM

1 PAGE – CONSENT FOR MEDICAL TREATMENT FORM

1 PAGE- IMMUNIZATION HISTORY

3 PAGES – REQUIRED FORM TO BE FILLED OUT BY PHYSICAN

1 PAGE – YOUTH CAMPER MEDICAL FORM

2 PAGES- YOUTH CAMPER HEALTH HISTORY

2 PAGES- YOUTH CAMPER VISUAL IMPAIRMENT / DISABILITY INFORMATION SHEET

1 PAGES – MEDICATION ADMINISTRATION FORM

1 PAGE – T-SHIRT ORDER FORM

17 TOTAL PAGES TO BE RETURNED TO keithdavid17@msn.com

Camp Abilities Olympia

Dear Camper,

Olympia Camp Abilities is coming near, and we are looking forward to having you for the weekend! There are a few things we want you to know before you come.

1. Please read the list of items to bring to camp, and try to bring everything on the list.

2. Please bring any equipment you may have, such as water bottles, bug spray, sun screen, CDs, tapes, and any special food you like. If you do not have any of this equipment it will be provided, but we wanted to give you the option to bring your own. Make sure you label everything with your name on it!

3. If you are a picky eater and think you may not like all the dinners (hot dogs, hamburgers, pizza, pasta, or subs), please bring some food that you will eat!

4. Camp will involve a lot of sports, games, and activities throughout the day. If you have not been active very much this year, we advise you to become involved in some light to moderate activities like stretching, running, walking, riding bikes, rollerblading, jumping rope, swimming, and any other physical activities which you enjoy. We want you to be involved 100 percent during the weekend and not get hurt.

You will learn a lot and make new friends. We are excited for this awesome weekend of activities and fun. If you have any questions, please do not hesitate to call.

Sincerely,

Keith Edgerton

Keith Edgerton
Camp Director

Suggested Clothing and Equipment

Please make sure name is securely on all items, especially valuables.

Sleeping bag (blanket and sheets) and Pillow (mandatory)

1 flashlight with extra batteries

1 warm jacket

1 sweater or sweatshirt

1 pair of jeans

2 pairs of shorts

2 shirts

1 hat

1 raincoat or poncho

2 pairs of shoes (in case their shoes get wet)****Please be sure child brings sneakers for activity!! (Running shoes, cross trainers, or tennis sneakers are best.)***

1 pair1 of pajamas

2 pairs of socks

2 pairs of underwear

1 bath towel

Toilet articles in plastic bag (toothbrush, comb, brush, toothpaste, shampoo, soap, etc.) Laundry

Sleeping Bag

Sleeping Pad

Pillow

Sunglasses

Sunblock (#15 or above)

Camera

**** Please bring the following if you have them:***

Your favorite music

Cards/games

Other items if you need them, Watch, Cane if, LV devices for watching activities

Permission Slip

Must be signed and returned in order for your child to attend camp.

Child's Name: ____

Address:____

City:____________________________ **State:**___________________**Zip:**____________

Home Phone:_____________________________**Work:**___________________________

Cell Phone: _______________________**E-mail:**_________________________________

Parent/Guardian Name:____

We (I) hereby give permission for the above named child to participate in the Olympia Camp Abilities. We (I) hereby waive and release Olympia Camp Abilities, and everyone involved, of any liability or claim in association with anything that might occur while my child is attending camp.

Date_______________Signature____________________________________

Camper Information Sheet

Dear Camper;

In order to give you the very best time at camp, we would like to get to know you - even before we meet you! Please take the time to complete the following information for your counselor.

Name:____ Address

City________________State_______Zip______ Date of Birth________________________Age

Do you read: Braille? Yes/No Large Print Yes/No Regular print Yes/No

Have you ever been to an overnight camp before?_____________If yes, when?_____________

What school do you go to?____________________________What grade are you in?_________

What are your favorite subjects?____

Do you have a nickname?____

Do you have any hobbies?____

What are your favorite sports?____

Do you have a friend that goes to [name of your camp]? Who?___________________________

Do you know how to swim?____________________ Do you like boat rides?_______________

What are your favorite crafts?____

What is your favorite outdoor or nature activity?

What is your favorite food?

Do you play an instrument? Which one?

Do you have any brothers or sisters? How old?

Do you have any pets? What are they and what are their names?

Do you have any concerns about your week at camp?

Other?____

Release Form

Name of Camper: ____

If the participant is on medication, bring enough medication to last the entire time at camp. Keep it in the original packaging/ bottle that identifies the prescribing physician (if prescription), name of the medication, the dosage, and the frequency of administration. All medications (prescription and over the counter) must be checked in with the nurse upon arriving at camp and will be returned upon leaving.

Parent/Guardian Authorization

Medical Release and History: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medication, and seek emergency medical treatment, including ordering Xrays 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 cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and ad- minister treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Photo Release

During the run of camp programs, staff members may take photographs/videos of various program activities and program participants for future promotional use. If you do not consent to having the above person used in promotional materials, check the box below. (Consent is not required for attendance.)

___Check if you DO NOT consent to photo/video release

Signature (Adult Camper or Parent/Guardian):

____Date:__________________________

Waiver of Liability and Hold Harmless Agreement for Olympia Camp Abilities

Note to camp organizers: This is a sample waiver. As it is a legal document, please consult with your legal advisors to make sure it is legal and has the proper wording for your state and your circumstances. This guidebook does not purport to give legal advice, and this waiver may not be binding in your state.

Olympia Camp Abilities is a week-long developmental sports camp for children ages 10-17 who are visually impaired or blind to be held during the weekend of October 1st and 2nd 2016 on the following site: Saint Martin's University – Lacey, WA.

1. In consideration for receiving permission to participate in Olympia Camp Abilities. I hereby RELEASE, WAIVE, DISCHARGE AND COVENANT TO INDEMNIFY or any of their officers, agents, servants, or employees (hereinafter referred to as RELEASEES) from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by me, or any of the property belonging to me, or otherwise, while participating in the CAMP.

2. I am fully aware of the potential risks and hazards connected with participating in Olympia Camp Abilities including but not limited to travel risks and/or medical or accident risks. I hereby elect to voluntarily participate in (*name of your camp*) with full knowledge that said activity may involve risk to me and my property. I VOLUNTARILY ASSUME FULL RE- SPONSIBILITY FOR ANY RISKS OF LOSS, PROPERTY DAMAGE OR PERSONAL INJU- RY, INCLUDING DEATH, that may be sustained by me, or any loss or damage of property owned by me, as a result of being engaged in (*name of your camp*).

3. I understand that I, as a Participant, should sustain or otherwise acquire and maintain an adequate insurance policy to any circumstance arising from my participation in (name of your camp), or any activity associated with or facilitating that participation.

4. It is my express intent that this Waiver of Liability and Hold Harmless Agreement shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representative, if I am deceased, and shall be deemed as a RELEASE, WAIVER, DIS- CHARGE AND COVENANT NOT TO SUE the above-named RELEASEES. I hereby further agree that this Waiver of Liability and Hold Harmless Agreement shall be construed in accordance with the laws of the State of Washington.

5. IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing Waiver of Liability and Hold Harmless Agreement, understand it and sign it voluntarily as my own free act and deed; no oral representations, statements, or inducements, apart from the foregoing written agreement, have been made; I am at least eighteen (18) years of age and fully competent; and I execute this Release for full, adequate and complete consideration fully intending to be bound by same.

Signed on this day: _________________, 2016.

PARTICIPANT__________________________

Printed Name __________________________________

Signature____

Date _________________

If Participant is under the age of 18, Parent/Guardian:1) consents to the minor's participation in the event; 2) consents for Olympia Camp Abilities or its agents or sub- contractors to seek reasonable and necessary medical treatment for Participant during the Event or associated activities, and agrees to be responsible for any costs thereof; 3) has read and understands and, by the signature below, agrees to these covenants as put forth in this Waiver of Liability and Hold Harmless Agreement.

Parent/Guardian Signature (Printed Name)_______________________________________

(Signature)____

(Date)______________________________

CONSENT FOR MEDICAL TREATMENT

TO WHOM IT MAY CONCERN:

I, ________________________________ hereby grant permission to the Medical Staff at Camp Abilities or in case of emergency, the community hospital, to administer treatment as necessary. This permission is granted for all of the Camp Abilities programs that I attend.

Name: ____________________________________

Date: ______________________
(PLEASE PRINT)

Signature: _________________________________

Address: ____

____ Tel.______________________

****

ALL STAFF UNDER THE AGE OF 18 MUST HAVE A PARENT OR GUARDIAN SIGN BELOW:

Parent or Guardian: _____________________________________
(PLEASE PRINT)

Signature: ___________________________________

Relationship: _________________________________

IMMUNIZATION HISTORY-

Note: Please record the date (month & year) of basic immunization and most recent booster doses.

Vaccines	Date of Immunization	Date of Booster
Diphtheria		
Pertusis (whooping cough) "DTP"		
Tetanus		
Tetanus Booster		
Oral Polio (Sabin, TOPV)		
Measles (hard measles, red measles, Rubella)		
Rubella (German Measles, 3-day)		
Other		

******* Students, check with your health center/nurses office to see if they have this info on file! A copy of forms submitted to your school will suffice******

or Group #_______________________________________

This form in its entirety must be completed by your child's Primary Physician

Dear Physician:

The following child has registered to attend camp at our facility. Our regulations require that a physician provide us with medical information based on any examinations done within one year of his/her camp attendance.

We will greatly appreciate your completing this form for that purpose.

Thank you in advance for your assistance.

Sincerely,

Keith Edgerton

Camp Director

Camper's Name: _____________________________________ Date of Examination: _______

Age ___________BP __________________ Weight ______________ Height _____________

MEDICATIONS:

- Please list ALL medications (including over-the-counter or non-prescription medications) taken routinely.
- Bring enough medication to last the entire camp.
- Keep it in the original packaging/bottle that identifies the prescribing physician (if prescription drug), the name of the medication, dosage, and the frequency of administration.
- Please provide plastic zip lock bag with the camper's name on it.

Please check:

___ This person takes NO medications on a regular basis.

___ This person takes medications as follows, including over-the-counter medications:

(Please attach separate sheet if needed.)

Name of Medication ______________________________**Dosage**____

Specific times taken each day ____

Reason for taking this medication ____

Name of Medication ______________________________**Dosage**____

Specific times taken each day ____

Reason for taking this medication ____

RECOMMENDATIONS AND RESTRICTIONS AT CAMP:

Description of prescribed meal plan or dietary restrictions: ____
____
____

Description of any physical limitations/restrictions:____
____
____

Additional information for health care staff at camp: ____
____
____

IMMUNIZATION HISTORY: PROVIDE THE MONTH AND YEAR OF LAST IMMUNIZATION FOR:

TDAP________________________Hepatitis B____________________________Polio_______________________

MMR___________________________HIB_______________________________FLU_______________________

Varicella_________________________Prevnar____________________________

This form must be completed by the physician/nurse practitioner/physician's assistant and sent back to camp PRIOR to the child's arrival. Below you will find a list of standard medications we use here at the camp and the standard dosage. Please initial the medications you used and sign and date below. If you have any additions or corrections, please use lines provided. Thank you.

****Please send any OTC medicines that are frequently or occasionally used by your child to camp with their name on it!****

Drug Name	**Route**	**Dosage**	**Schedule**	**Provider Order**(circle)
Benadryl (25 or 50 mg)	po	per label instructions	q 6 hrs prrn for allergic	YES
		By weight/age	reaction (hives, bites)	NO
Tylenol	po	per label instructions	q 4 hrs prn for pain or	YES
		By weight/age	fever > ____F	NO
Ibuprofen (200-400mg)	po	per label instructions	q 6 hrs for pain or	YES
		By weight/age	fever > ____F	NO
Tums (2 tabs)	po	per label instructions	TID prn for stomach upset	YES
		By weight/age		NO
Pepto Bismol	po	per label instructions	TID prn for stomach upset	YES
		By weight/age	(no > 4 doses in 24 hrs)	NO

Drug Name	**Route**	**Dosage**	**Schedule**	**Provider Order**(circle)

Robitussin	po	per label instructions By weight/age	q 4 hours prn for cough	YES NO
Chlora Spetic spray/ Cough drops	po	per label instructions By weight/age	q 2 hrs prn for sore throat (no>4 doses in 24hrs or fever)	YES NO
Neosporin	topical	per label instructions By weight/age	prn as directied for minor cuts and abrasions	YES NO
Solarcaine	topical	per label instructions By weight/age	prn for insect bites or sunburn	YES NO
Sun Screen	topical	per label instructions By weight/age	prn for sun protection	YES NO
Cold/Allergy Medicine	po	per label instructions By weight/age	q 6 hrs prn for nasal congestion	YES NO
Imodium	po	per label instructions By weight/age	TID prn for stomach upset (no>4 doses in 24hrs)	YES NO
Camper may administer own inhaler				YES NO

Printed Name ____Date__________________________________

Signature of Physician/Nurse Practitioner/Physician's Assistant:
____

Address ____Phone _________________________________

YOUTH CAMPER MEDICAL FORM

Camper (Full)Name ____

DOB _______________ Age at Camp____________Sex(M/F)_________Height_________Weight_________

Full Mailing Address:

____

Number of Year's attending Camp Abilities ___________________

Parent or Guardian Information:

Name: ____ Home Phone________________

Cell Phone ___________________ Work Phone ________________

Name: ____Home Phone ________________

Cell Phone ___________________ Work Phone _________________

Email Address: ____

If not available in an emergency, call:

Name ____ Home Phone____________Cell Phone____________

Work Phone ____________________ Relationship to Camper ____

Full Mailing Address ____

Medical Insurance Information

Is the camper covered by family medical/ hospital insurance? Yes ___ No ____ (Please fill out information below)

Name of Insurance Company ____

Address ____Phone Number _______________________

Carrier/Plan Name ________________________Policy ID #____________________Group #_____________

Any Additional Information you would like to Add:

____

____

____

____

____

____

HEALTH HISTORY: THIS MUST BE COMPLETED BY PARENT/GUARDIAN

The intent of this information is to provide the camp health care staff with the background to render appropriate care. If there are any changes in participant health, prior to camp, the health care staff should be notified upon the participant's arrival at camp.

Camper Name:* ____*(In case form is separated)

ALLERGIES: List allergy, describe reaction, and management of the reaction:

Medication Allergies: ____

Food Allergies:____

Require any special foods?____***History of Eating Disorder?***___________

Describe Reaction/Management: ____

Other: (airborne, stings, animals, latex etc.) ____

History: Give the approximate dates for the following: (Further explain on the lines given below further if any of the following have occurred or pertain to the camper's current health status and list any medications they may be taking for these issues ie. Asthma __yes__ list medication/treatment)

Recent Injury/Illness ____________	**Chronic Injury/Illness**__________	**Constipation** _________
Ear, Nose Throat disorder ___________	**Mononucleosis** __________	**Poison Ivy** _________
Heart defect/disease ____________	**Convulsions** __________	**Shingles** _________
Bleeding/clotting disorder __________	**High Blood Pressure** _______	**Asthma** _________
Chicken Pox ____________	**Mumps** __________	**Diarrhea** _________
German Measles ____________	**HIV/AIDS** __________	**Hepatitis** _________
Skin Problems (rash, itching etc.) _____	**Orthopedic Problems** ______	**Have/Had Cancer** _______
Ear Infection/Surgery ____________	**Back or Neck Problems**_______	**Kidney Disease** _________
Recent Infectious Disease ___________	**Dental issues/Orthodontic Appliance/Braces** ____________________	

Menstrual Cycle (Any problems with this?)____

Head Injury (date, lasting effects, symptoms, special adaptations?) ____

Diabetes (medication, diet restrictions?) ________________________ **Difficulty Walking (3-5 miles per day)** _____

Wear glasses/contacts/protective eyewear ________________________ **Sleepwalking/Bedwetting** ________

Hearing Impairment (cochlear implant, aids) _________________________ **Need Interpreter?** _______________

Seizures (Date of last seizure? What type of seizure? Duration of seizure? Medication?(state drug and dosage)

____

Emotional Difficulties (anxiety, depression etc.) (Treatment: Medication/Counseling)______________________________

Any Additional Information you would like to Add: (Further explanation of medicines or conditions listed above.)
____
____
____
____
____
____

Camper Name: ____(In case form is separated)

This health history is correct as to my knowledge, and the person herein described has permission to engage in all prescribed camp activities except as noted.

EMERGENCY AUTHORIZATION: I hereby give permission to the medical personnel selected by the Camp Executive Director to order x-rays, routine tests and treatment for my child, and in the event I cannot be reached in an emergency. I hereby give permission for the physician selected by the Camp Executive Director to hospitalize, secure proper treatment for, and to order injection and/or anesthesiaa and/or surgery for my child as named above. This form may be photocopied for use of camp.

Signature of Parent/Guardian _______________________________________Date ________________________

I also understand and agree to abide with restrictions placed on my camp activities.

Signature of Minor ____Date _______________________

YOUTH CAMPER INFORMATION

Camper Name: ____________________________

We would like to have as much information on your child's visual impairment as well as any other information on any other disability your child may have. Please take the time to answer the questions below. This will be beneficial for the counselors and specialists working with your child to understand their needs better as well as to collect information for the research that will take place this year at Camp Abilities.

Please check which classification your child falls into:

______ **Class B1:** No light perception in either eye up to light perception, but inability to recognize the shape of a hand at any distance or in any direction.

______ **Class B2:** From ability to recognize the shape of a hand up to visual acuity of 20/600 and/or a visual field of less than 5 degrees in the best eye with the best practical eye correction.

_______ **Class B3:** From visual acuity 20/600 and up to visual acuity of 20/200 and/or a visual field of less than 20 degrees and more than 5 degrees in the best eye with the best practical eye correction.

_______ **Class B4:** From visual acuity above 20/200 and up to visual acuity of 20/70 and a visual field larger than 20 degrees in the best eye with the best practical eye correction.

Please list diagnosis, limitations, and if any adaptations are needed: ____________________________________

____

Please answer the following questions: Please use the space provided only if you need to provide additional information. Please be as specific as possible!

1. My child has difficulty going from dark to light places? Yes No

Explain:____

2. My child has difficulty going from light to dark places? Yes No

Explain:____

3. My child has a good sense of peripheral vision? Yes No

Explain:____

4. My child has good sense of central vision? Yes No

Explain:____

5. My child has tunnel vision? Yes No

Explain:____

Camper Name: _____________________________(in case separated)

Disability *(mark all that apply)*

_____ Learning Disabled

_____ Intellectual Disability

_____ Physically Impaired

_____ Hearing Impaired

_____ Brain Injury

_____ Spina Bifida

_____ ADD/ADHD

_____ Cerebral Palsy

_____ Down Syndrome

_____ Multiple Sclerosis

_____ Autism

_____ Speech Impaired

_____ Emotionally Disturbed

_____ Other ________________________________

Explain ____

Behavior *(mark all that apply)*

_____ Hyperactive

_____ Temper Tantrums

_____ Loud or Abusive Language

_____ Hits others

_____ Socially Isolated

_____ Inappropriate Sexual Behavior

Cognitive Ability ____

Communication Skills ____

Mobility

______Walks without assistance

______Walks with use of cane

_____Walks with other device Explain, ____

______Uses a wheelchair

Specify type and degree of assistance required in each area:

Eating ____________________________________ **Dressing** ____

Grooming _________________________________ **Bathing** ____

Toileting __________________________________ **Bedtime Routine** ____________________________________

Uses protective undergarment

Additional Information: ____

MEDICATION ADMINISTRATION: THIS MUST BE COMPLETED BY PARENT/GUARDIAN

Name of Parent: _________________________ Name of Camper: ______________________

Please List all medication your child is currently taking: ***Please Be Specific!***

Name of Drug	Dose	Frequency and & Times Given	Side Effects

This concludes the Medical Registration/Information needed to be received in order for your son or daughter to participate in Camp Abilities Olympia 2016.

**** Remember that your physician is required to fill out the physician medical form by law.****

CONTACT OUR STAFF FOR CHANGES BEFORE CAMP!!!

Please do this so medication records can be modified for your child. This will be greatly appreciated to speed up the registration process on the first day of camp.

- **ALSO, please don't forget to put ALL of your child's medications in a zip-lock bag with the child's name on the front. This will speed up the registration process.**
- **ALL medications need to be in the original bottle and not expired.**

Thank you! We look forward to seeing you at camp.

Keith Edgerton

360-915-2223

Keithdavid17@msn.com

Camp Abilities Olympia
T-Shirt Order Form

Name: ____

___ **CAMPER**

___ **VOLUNTEER**

Free Shirt: Please select one:

ADULT

___ **SMALL**

___ **MEDIUM**

___ **LARGE**

___ **X-LARGE**

YOUTH

___ **SMALL**

___ **MEDIUM**

___ **LARGE**

___ **X-LARGE**