

Athlete Registration Camp Abilities Olympia Information Packet Checklist

Parent Name(s) _____

Camper name _____

FORMS THAT NEED TO BE RETURNED NO LATER THAN MAY 5, 2017. PLEASE EMAIL AS A PDF TO Keithdavid17@msn.com

1 PAGE – PERMISSION SLIP

2 PAGES - SUDDEN CARDIAC ARREST INFORMATION FORM

2 PAGES - CONCUSSION INFORMATION FORM

1 PAGE – CHILD INFORMATION SHEET

1 PAGE- RELEASE FORM

2 PAGES - SWIM INFORMATION FORMS

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

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

Camp Abilities Olympia

Dear Camper,

Olympia Camp Abilities is going to be here before you know it and we are looking forward to having you for the 4 day camp! There are a few things we want you to know before you come.

- 1) The cost of the camp this year is \$450. We have raised a lot of money but we are unable to fund the entire camp ourselves. Checks can be made out to you Olympia Camp Abilities PC or you can make a \$450 donation on our website at www.campabilitiesolympia.com If you really want your child to attend this camp but have the financial concerns, please let me now. **NO child will be turned away because of financial concerns.**
- 2) Please read the list of items to bring to camp, and try to bring everything on the list.
- 3) 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!
- 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.
- 5) We allowed some of parents to attend the first weekend camp we held in 2016, but this summer camp will not have parent participation. One of the main goals of this camp is too help the athletes become advocates for themselves in life. Parents will be welcome on the last day to celebrate all of the accomplishments the athletes achieved during the four day camp.
- 6) 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

2 pairs of jeans

2-3 pairs of shorts

3-4 shirts

1 hat

1 raincoat or poncho

3 pairs of shoes (1 sneakers, 1 pair hiking shoes, 1 pair sandals or open-toed shoes for hot weather)

***Please be sure child brings sneakers for activity!! (Running shoes, cross trainers, or tennis sneakers are best.)*

2 pairs of pajamas

4-5 pairs of socks

4 pairs of underwear

1-2 swimsuits

1 beach towel

1 bath towels

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

Sunglasses

Backpack or day pack

Sunblock (#15 or above)

Camera

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

Life jacket

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

Date _____ Signature _____

Sudden Cardiac Arrest Information Form

Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs. SCA doesn't just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A youth athlete's SCA will likely result from an inherited condition, while an adult's SCA may be caused by either inherited or lifestyle issues. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?

SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year. It is the #1 cause of death for student athletes.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- fainting or seizures during exercise;
- unexplained shortness of breath;
- dizziness;
- extreme fatigue;
- chest pains; or
- racing heart.

These symptoms can be unclear in athletes, since people often confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it.

Public Chapter 325 – the Sudden Cardiac Arrest Prevention Act

The act is intended to keep youth athletes safe while practicing or playing. The requirements of the act are:

- All youth athletes and their parents or guardians must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.

Adapted from PA Department of Health: Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form. 7/2013

- The immediate removal of any youth athlete who passes out or faints while participating in an athletic activity, or who exhibits any of the following symptoms:

- (i) Unexplained shortness of breath;
- (ii) Chest pains;
- (iii) Dizziness
- (iv) Racing heart rate; or
- (v) Extreme fatigue; and

- Establish as policy that a youth athlete who has been removed from play shall not return to the practice or competition during which the youth athlete experienced symptoms consistent with sudden cardiac arrest
- Before returning to practice or play in an athletic activity, the athlete must be evaluated by a licensed medical doctor or an osteopathic physician. Clearance to full or graduated return to practice or play must be in writing.

I have reviewed and understand the symptoms and warning signs of SCA.

Signature of Student-Athlete	Print Student-Athlete's Name	Date
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Signature of Parent/Guardian	Print Parent/Guardian's Name	Date
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CONCUSSION INFORMATION FORM

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

- Headaches
- “Pressure in head”
- Nausea or vomiting
- Neck pain
- Balance problems or dizziness
- Blurred, double, or fuzzy vision
- Sensitivity to light or noise
- Feeling sluggish or slowed down
- Feeling foggy or groggy
- Drowsiness
- Change in sleep patterns
- Amnesia
- “Don’t feel right”
- Fatigue or low energy
- Sadness
- Nervousness or anxiety
- Irritability
- More emotional
- Confusion
- Concentration or memory problems (forgetting g
- Repeating the same question/comment

Signs observed by teammates, parents and coaches include:

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily or displays in coordination
- Answers questions slowly
- Slurred speech
- Shows behavior or personality changes
- Can’t recall events prior to hit
- Can’t recall events after hit
- Seizures or convulsions
- Any change in typical behavior or personality
- Loses consciousness

What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is the key to student-athlete’s safety.

For current and up-to-date information on concussions you can go to <http://www.cdc.gov/ConcussionInYouthSports/>

Athlete/Parent Consent and Acknowledgements

By signing this form, we acknowledge we have been provided information regarding concussions. **Athlete**

Athlete Name (Print): _____ Grade: _____

Athlete Signature: _____ Date: _____

Parent or Legal Guardian

Name (Print): _____

Date: _____

Signature: _____

Relationship to Athlete _____

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 administer 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: _____

Swim Information Form

Athlete Name _____ Date _____

Parents: Please check the category that most applies to your son or daughter's swimming abilities. All athletes will be tested so if you are not sure you can leave it blank or describe what you do know.

Pre-Level 1: Enters the water hesitantly or not at all, clings to wall or caregiver, does not put face in water, does not take feet off the ground.

Level 1: Puts face in water hesitantly or when urged, moves away from the wall and plays, does not mind being splashed, attempts to swim.

Level 2: Swims underwater, can roll from front to back, swims short distances above water with face in, takes a breath and resumes swimming without standing up, jumps in from side of the pool into chest-deep water.

Level 3: Swims 25 yards without stopping, does rhythmic breathing toward side but needs to work on it, swims 10 yards on the back, can jump into deep water (over the head) and recover easily.

Level 4: Swims on front, back, and side with basic form at least 50 yards, treads water 3 minutes in deep end, performs at least a sit dive in water 9 feet or more, performs the basics of side stroke and breaststroke, can swim down to 7 feet and retrieve an object.

Level 5: Swims basics of all strokes including freestyle, breaststroke, backstroke, elementary backstroke, some sidestroke, beginning of butterfly, can perform a dive off the side, has been off a diving board, can tread water up to 4 minutes, can float on back.

Level 6: Can swim all strokes for 100 yards or more, perform dive off diving board; knows in-water surface dives, understands and performs personal rescue skills, knows basic pool area first aid.

If already passed American Red Cross Learn to Swim Level, what is last level completed? When?

Please state Health Issues, Secondary Disabilities, and Precautions in Aquatic Environment:_____

Has this swimmer been on a swim team? _____What is his/ her stroke?_____

What is his/her best time for a 50 yard or meter swim (if applicable)_____

Waiver of Liability and Hold Harmless Agreement for Camp Abilities Olympia

Camp Abilities Olympia is a (4) day developmental sports camp for children ages 9-19 who are visually impaired or blind to be held from August 8th-11th, 2017 on the following site: Saint Martin's University - Lacey, WA.

1. In consideration for receiving permission to participate in Camp Abilities Olympia. I hereby RELEASE, WAIVE, DISCHARGE AND COVENANT TO INDEMNIFY or any of their officers, agents, servants, or employees (hereinafter referred to as RELEASES) 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 Abilities Olympia.
2. I am fully aware of the potential risks and hazards connected with participating in Camp Abilities Olympia 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 RESPONSIBILITY FOR ANY RISKS OF LOSS, PROPERTY DAMAGE OR PERSONAL INJURY, 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 Camp Abilities Olympia.
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 Camp Abilities Olympia, 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, DISCHARGE AND COVENANT NOT TO SUE the above-named RELEASES. 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: _____, 2017.

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 Camp Abilities Olympia 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 Olympia or in case of emergency, the community hospital, to administer treatment as necessary. This permission is granted for all of the Camp Abilities Olympia 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 _____ Pevnar _____

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

- | | |
|--|--|
| <input type="checkbox"/> Learning Disabled | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Physically Impaired | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Speech Impaired |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Emotionally Disturbed |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Other _____ |

Explain _____

Behavior (mark all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Hits others |
| <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Socially Isolated |
| <input type="checkbox"/> Loud or Abusive Language | <input type="checkbox"/> Inappropriate Sexual Behavior |

Cognitive Ability _____

Communication Skills _____

Mobility

- | | |
|---|---|
| <input type="checkbox"/> Walks without assistance | <input type="checkbox"/> Walks with use of cane |
| <input type="checkbox"/> Walks with other device | Explain, _____ |
| <input type="checkbox"/> 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