

Camp New Hope Annual Information Form

Participant's Name _____ Preferred name, if any: _____

Camper's age: _____ Date of Birth: _____ Weight: _____ Height: _____ Gender: Male Female

Camper's Address, city and zip code _____

Contact person at above address _____ Contact Person's Phone Numbers _____

Name of Parent or Guardian _____ Parent/Guardian's Email address _____

Parent/Guardian Address _____

Parent/Guardian Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact (other than persons listed above) Name: _____

Emergency Contact Home Phone: _____ Work Phone: _____ Cell Phone: _____

Doctor's Name: _____

Does the camper reside at a group home, CILA, or Independent Living Residential Program (ILRP)? Yes No

Must be completed for group home, CILA or ILRP residents:	Case Manager Name _____ Phone: _____
	Pager/24 hour contact Phone Number(s): _____
	Alternate Contact at CILA or agency: Name _____ Phone: _____

Allergies			
	YES	NO	If yes is marked, describe in detail what the participant is allergic to.
Food Allergy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication Allergy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insect Bite/Sting Allergy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any other allergies?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Describe allergic reactions :			
Does Participant have any special dietary needs? _____			
If yes , describe special dietary needs and special food preparation requirements:			

What size T-Shirt does the Camper wear?			
<input type="checkbox"/> Youth SM <input type="checkbox"/> Youth M <input type="checkbox"/> Youth L <input type="checkbox"/> Adult SM <input type="checkbox"/> Adult M <input type="checkbox"/> Adult L <input type="checkbox"/> Adult XL <input type="checkbox"/> Adult XXL <input type="checkbox"/> Adult XXXL			

Who is responsible for paying the camper fee? Circle One: **Parent** **Self** **Other (specify below)**

Sponsor name _____

Sponsor address, city, state _____

Sponsor contact person: _____ Sponsor Phone: _____

If you request financial aid we ask that you complete a "Financial Aid Information Form" which you may obtain from our office or on the website, www.myfavoritecamp.org

Medications

Does Participant use any medications (include over-the-counter): _____

If yes is marked, list all medications—use another sheet if needed:

Medication name	Dosage	Time

Participant Needs & Health

Does participant use injections of any kind? Describe: _____

Is participant subject to seizures? _____

If yes, complete the following:

Type of seizure: _____

Frequency: _____

Last seizure date: _____

Is participant aware of impending seizure? If yes, describe: _____

Describe care required during/after seizure: _____

Behavior and Communications

Any disruptive behaviors? Describe or respond "no" if none: _____

Does participant respond to specific behavior techniques? Describe: _____

Situations/Activities/Foods that can cause behavior problems? Describe: _____

Does participant usually comply with verbal requests/directions? _____

Does the participant verbalize clearly? Describe if no or write "yes" if they do verbalize clearly: _____

Describe special Communications needs or instructions (sign language, special gestures, etc.): _____

Is there any possibility participant behavior would risk injuring self or others? Describe if yes or respond "no" if there is no possibility. _____

Is the participant usually willing to share/take turns? _____

Does the participant tend to give up or become frustrated when confronted by challenging activities? _____

Is the participant ever violent or dangerous to others? If yes please explain: _____

Safety and Social Skills

Has camper ever attended Camp New Hope? ____ If yes, did camper have any problems here? _____

Is homesickness likely to occur? _____

Will participant stay with a group? _____

Can participant be responsible for own belongings? _____

Is participant able to recognize danger? _____

Best way to get participant involved: _____

Favorite Activities: _____

Situations which may cause fearfulness or upset: _____

Daily Living Skills

Does participant have a toileting schedule? Describe schedule or write "no" if no schedule. _____

Needs assistance with toileting- Explain assistance needed or write "no" if no assistance needed. _____

<p>Select items which apply:</p> <p><input type="checkbox"/> Bedwetting: <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent <input type="checkbox"/> None</p> <p><input type="checkbox"/> Needs help showering <input type="checkbox"/> Needs help washing <input type="checkbox"/> Needs help toothbrushing <input type="checkbox"/> Needs help dressing <input type="checkbox"/> Needs help eating <input type="checkbox"/> Needs help with menstrual cycle</p>	<p>Please explain items checked in left column:</p>
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Select items which apply:

- Educable Mentally Handicapped
- Trainable Mentally Handicapped
- Severe/Profound Mentally Handicapped
- Learning Disabilities- Describe _____
- Down syndrome
- Autism
- Mental Illness- Diagnosis & Description _____
- Hearing Impaired- Describe _____
- Visually Impaired- Describe _____
- Behavior Disorder- Describe _____
- Physical Limitations- Describe _____
- Asthma
- Communicable Disease
- Diabetes ➔ Uses Injections No injections Must check blood sugar at least daily
- Heart Condition
- Shunt
- Other condition- Describe _____

Does participant use:

- Eyeglasses
- Ear plugs for swimming
- Nose Plug for swimming
- Walker
- Helmet
- Hearing Aid
- False Teeth
- Crutches
- Leg Brace
- Gait Belt
- Wheelchair
- Transfers independently
- Transfers with assistance
- Other Adaptive Equipment- Describe _____

Please list any information concerning participant that would aid our staff in ensuring their time at camp is safe and enjoyable.

If there are any dates that the camper will be UNABLE to attend during the summer, please note them here.

Custodial Parent, Guardian or Participant (if own Guardian) Must Sign:

In signing this form, I hereby certify that the above information is correct. I give permission for the participant to attend all camp activities including transportation of this participant in privately owned vehicles or public transportation for approved out-of-camp activities.

I agree to any emergency treatment by physician or hospital in the event I cannot be reached. I understand that all medication brought to camp must be clearly labeled as to content, administration times, and dosage.

I understand and assume all the risks associated with participation in an outdoor camping and aquatics program. I relieve Camp New Hope, Inc. from all claims or causes of action arising from this camper's participation.

I acknowledge that Camp New Hope, Inc. provides accident insurance for every camper; however, the camper's own family insurance is primary, and Camp New Hope's is secondary.

I give permission to use the camper's name and picture in publicizing the work and program of Camp New Hope, Inc.

I recognize the obligation of the Camp Director, in his/her absolute discretion, to terminate the camper's stay at any time due behaviors or medical conditions which might jeopardize the camper's or others' well being.

I will be financially responsible for any medical treatment that is needed for the participant.

Signature _____ Date _____

Relationship to Participant _____

- Applicants will be accepted regardless of race, color or national origin.
- Please check to see that all questions have been answered.
- Questions? Call the camp office between 9am and 4pm, Monday through Friday, at (217)895-2341. Some information is available online at our website, www.myfavoritecamp.org.

Mail completed forms to **Camp New Hope, Inc., PO Box 764, Mattoon, IL 61938**

Completing application does not guarantee participation.
Incomplete Applications will be returned.
This form is due on April 1st.