For questions call
262-275-6131 Ext 222
Form updated 2019 January 25

Camp Thrive Health Information

Complete and return this form in one of the following ways:

Mail To: Inspiration Ministries, P.O. Box 948, Walworth, WI 53184
Email To: jmclafferty@InspirationRetreatCenter.org
Fax To: 262-275-3355

Your registration will not be complete until this Health Information Form and Medical Approval is completed and received by June 7, 2019

This Health Information/Medical Approval Form is applicable only for camping year 2019.

APPLICANT INFORMATION

APPLICATION COMPLETED BY: ____

RELATIONSHIP TO CAMPER: ____

DAYTIME PHONE: (______) ________________ EVENING PHONE: (______) ______________________________

Camper Name:____

Address:____

City: ________________________________ State: ___________ Zip: ___________________________

Day Phone: (______)________________________ Evening Phone: (______)__________________________

EMAIL: ____

Age: __________ Date of Birth:______________________ Gender: _____ M _____ F

RESIDENCE: Private ______ Name of Group/Foster Home: ______________________________________

Parent/Caregivers Name: ____

Address: ____

City: ____________________________________ State: ___________ Zip:________________________

Day Phone: (______)______________________ Evening Phone: (______)__________________________

Name of family physician: ________________________ Phone: (______)_____________________________

Name of dentist: _______________________________ Phone: (______)______________________________

For emergency purposes, this section MUST be completed by ALL guests. Include insurance POLICY NUMBER or MEDICAL ASSISTANCE NUMBER. Guests are responsible for all medical bills incurred at camp.

Social Security Number: ______-_____-______ Medical Assistance Number:________________________ If guest is not covered by Medical Assistance, please list insurance carrier and policy number:

Insurance Carrier:________________________________ Policy Number: ___________________________

EMERGENCY CONTACT: (Person to contact if parent/caregiver cannot be reached. MUST be available during entire student session dates.)

1. NAME: ________________________________ Relationship to Guest:______________________________
   Day Phone: (______)_____________________ Evening Phone: (______)____________________________
2. NAME: ________________________________ Relationship to Guest:______________________________
   Day Phone: (______)_____________________ Evening Phone: (______)____________________________

Enter camper last name here _______________ to ensure application file is complete

PERSONAL CARE INFORMATION (Please take your time and complete accurately)

PHYSICAL DISABILITY: (name & description)
Primary Physical Disability (C.P., Spina Bifida, etc.) ____
Secondary Disability (if any) ____

COGNITIVE ABILITY: (check one)
❒normal functioning ❒ mild developmental delay (educable)
❒moderate developmental delay (trainable) ❒ severe developmental delay

IMMUNIZATIONS:
Up to Date: ❒ Yes ❒ No
Attach list of vaccinations and dates.

ALLERGIES: ❒ None ❒ Food (see "Diet" section below) ❒ Drug ❒ Environmental ❒ Other
List specific allergy & explain reaction: ____
____

Is an inhaler or epinephrine pen needed? ❒ No ❒ Yes – indicate type of inhaler or epi pen: _________
____

(Note: If inhaler or epinephrine pen will be needed by camper, a **Medication Self-Administration Consent Form** must be attached to this Health Information Form; a copy of the Consent Form is part of this forms package).

SEIZURE DISORDERS: (Check appropriate disorders)
❒ no seizures ❒ grand mal ❒ petit mal ❒ psychomotor ❒ nocturnal ❒ mixed
Seizure frequency: ____
Date of last seizure: ______________________

DISEASES/PAST ILLNESSES (check all that apply)**:**
❒Diabetes ❒Asthma ❒Chicken pox ❒Measles ❒Polio ❒Mumps ❒TB ❒Whooping cough
If diabetic, do you take insulin? ❒ No ❒ Yes If yes, is insulin self-administered? ❒ No ❒ Yes

MOBILITY:
Can you walk: ❒ Unaided ❒ With Assistance
Aides: ❒ Use Crutches ❒ Use Walker ❒ Use Cane ❒ Use Wheelchair
Can you propel yourself? ❒ Yes ❒ No
Do you use a power wheelchair/scooter? ❒ Yes ❒ No
Can you support your own weight for transfer? ❒ Yes ❒ No Height: ________ Weight: ________

DIET: ❒ Regular ❒ Restrictions (explain): ____

❒ Special (explain): ____

EATING:

❒ Independent/needs no assistant ❒ Needs assistance with ___________________________

❒ Dependent – must be fed (please provide a week's supply of disposable bibs & straws if needed)

Appetite: ❒ Large ❒Medium ❒ Small ❒ Limit helpings

SPEECH & COMMUNICATION: ❒Verbal ❒ Non-verbal

Able to read? ❒ Yes ❒ No Able to write? ❒ Yes ❒ No Able to talk? ❒ Yes ❒ No

If speech is severely limited, what Language Device is used? (Please bring) ______________________________

ACTIVITIES:

Swimming: ❒ Independent ❒ Uses life vest ❒ Cannot swim ❒ Fears water

Please list any activities the camper should not participate in, or may fear (swimming, zip line, archery, nature center, etc.): ____

BEHAVIOR (check all that apply):

❒ Generally happy (circle all that apply): Compliant Social Helpful Cooperative

❒ Generally unhappy (circle all that apply): Non-compliant Withdrawn Prone to depression

❒ Does well in large groups ❒ Does NOT do well in large groups

❒ Physically abusive/aggressive (circle all that apply): To self To others To staff

❒ Autistic behavior (describe): ____

Are there any behavior problems you handle in specific ways and would for us to continue? (We will try to be consistent with expectations and discipline at home if verbal instructions are inadequate.)

____

SELF CARE & DRESSING:

❒ Independent/needs no assistance

❒ Assistance needed because applicant is (circle applicable response): Slow Needs prompts

❒ Unable to dress self without assistance – please explain: ____

❒ Totally dependent

❒ Needs assistance with personal hygiene – describe: ____

❒ Needs assistance with bathing – describe: ____

Usual bedtime: _______________ Usual awakes: _______________

Special sleeping habits: ____

❒ written instructions for specific care needs are listed on a separate page

TOILET NEEDS (send adequate supplies for needs):

❒ Independent/needs no assistance

❒ Needs assistance with: ___________________________________

❒ Totally dependent (circle applicable dependency): Catheter Colostomy

❒ Uses Depends/diapers (circle applicable situation): At all times Only at night

(Bring enough supply to last entire week)

❒ Incontinent (circle applicable situation): Bowel Bladder (Depends will be used)

❒ Wets bed (supply adequate bedding, clothing, and /or Depends as there is no laundry service)

❒ Female guest able to self-care during menstruation:

❒ Fully ❒ Partially ❒ Not at all ❒ Expected during week

Photo/Public Relations Consent and Release

I understand that *Inspiration Ministries* may wish to use my name, photograph and/or stories with its work and that it needs the appropriate consent to do so. To assist *Inspiration Ministries* in carrying out its work, I hereby give my permission *to Inspiration Ministries* to release to the news media, or use for other marketing and communications purposes, photographs, films or audio recordings concerning myself. I also release *Inspiration Ministries*, its successors, employees, directors, agents, representatives or contractors from all claims for injury, loss or damages which I have, may have in the future, or might have had for whatever reason, arising out of such use. I hereby warrant that I have the full power to give this consent to sign this release. I understand *Inspiration Ministries* will not compensate me.

Signature: ____ Date:______________________________

Parent or caregiver for: ____

CAMP THRIVE APPLICATION RELEASE FORM

I give permission as legal guardian for the camper to attend Camp Thrive. To the best of my knowledge, all signatures and information in the application are/is correct and the person herein described has my permission to engage in all activities, except as noted by myself and/or physician. I further understand that Inspiration Ministries reserves the right to reject any applicant whose needs cannot be met by staff.

I understand that due to specific state laws and Inspiration Ministries policy, ALL medications, whether prescription or non-prescription, brought to Camp Thrive MUST be in blister packs or original container/prescription bottle, clearly marked with the name, dosage, frequency, times, and prescribing physician, and not in pre-poured containers, except for those pre-poured from a pharmacy, with prescribing physician and pharmacy clearly identified. Camper will not be allowed to stay if this policy is not followed. I agree not to send applicant if exposed to a contagious disease within three weeks of the event, and I will notify Inspiration Ministries if guest must cancel. No one will be denied attendance at Camp Thrive because of religion, creed, national origin, sex, age or disability.

Emergency Consent: I, the undersigned, parent or legal guardian of the applicant, do hereby authorize the director or responsible medical staff acting on behalf of Camp Thrive, to act as my Agent, to consent to medical, surgical or dental examination and/or treatment. In the event I cannot be reached in an EMERGENCY, please contact the emergency contact person listed on camper's application. I give permission to the Health Care Professional selected by the Camp Thrive staff to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery. I assume financial responsibility for any medical treatment not covered by Inspiration Ministries insurance.

Waiver of Liability: I release and hold harmless Inspiration Ministries, its board of directors, staff, leadership, and volunteers, from liability due to negligence by Camp Thrive staff, leadership and volunteers. I shall bring no claims, demands, or litigation against Inspiration Ministries for losses due to bodily injury, death or property damage arising out of or related to participation at Camp Thrive.

Disclaimer and Permission: I, the parent or guardian of the applicant, acknowledge that participation in all camp-related activities necessarily involves risk of physical injury. I further acknowledge that the programs of Camp Thrive are primarily administered by adults, who volunteer their time. I attest that applicant is physically capable to participate in this event. However, should directors, representatives, medical staff or volunteers determine in their sole discretion that participation in any games, events, or activities would be injurious to camper's health, or should camper become ill or injured, I consent to his or her removal from that activity and/or treatment by any physician or medical care provider at the direction of the Camp Thrive director.

Enter camper last name here ________________ to ensure application file is complete

The information contained in this application is correct, to the best of my knowledge. I have read, understand, and agree to the above statement and agree with the aforementioned terms and conditions subject to attending Camp Thrive.

Signature of Legal Guardian: ____

Date: _______________________________________

Or Camper signature if own legal guardian: ____
(Applications cannot be processed without proper signatures)

A CONFIRMATION OF ACCEPTANCE WILL BE SENT AS SOON AS ALL FORMS ARE REVIEWED

MAIL COMPLETED APPLICATION WITH GUARDIAN'S AND PHYSICIAN'S SIGNATURES TO:

Inspiration Ministries
Attn: Camp Thrive
PO Box 948
Walworth, WI 53184-0948

Note: Please have your physician complete pages 7 – 8 of this Health Information/Medical Approval Form.

Camp Thrive Medication Self-Administration Consent Form
Inhaler and/or Auto-Injectable Epinephrine

Please complete this form if applicable

Camper's Name (Please Print) ____

Type of inhaler ____

This form is good for camping year 2019 only. This consent form must be updated anytime the camper's medication order changes and must be renewed each year.

The following must be provided for the camper to be eligible to self-administer rescue inhalers and/or auto injectable epinephrine. Eligibility is **only** valid for this camp for the current year.

- a written statement from a licensed health-care provider who has prescriptive privileges that he/she has prescribed the rescue inhaler and/or auto-injectable epinephrine for the camper and that the camper needs to carry the medication on his/her person due to a medical condition;
- the specific medications prescribed for the camper;
- an individualized health care plan developed by the prescribing health-care provider containing the treatment plan for managing asthma and/or anaphylaxis episodes of the camper and for medication use by the camper during camp hours; and
- a statement from the prescribing health-care provider that the camper possesses the skill and responsibility necessary to use and administer the asthma inhaler and/or auto-injectable epinephrine.

If the camp nurse is available, the camper shall demonstrate his/her skill level in using the rescue inhalers and/or auto-injectable epinephrine to the nurse.

Rescue inhalers and/or auto-injectable epinephrine for a camper's self-administration shall be supplied by the camper's parent or guardian and be in the original container properly labeled with the camper's name, the ordering provider's name, the name of the medication, the dosage, frequency, and instructions for the administration of the medication (including times). Additional information accompanying the medication shall state the purpose for the medication, possible side effects, and any other pertinent instructions (such as special storage requirements) or warnings.

Campers who self-carry a rescue inhaler or an epinephrine auto-injector shall also provide the camp nurse with a rescue inhaler or an epinephrine auto-injector to be used in emergency situations.

My signature below is an acknowledgment that I understand that Camp Thrive and constituents shall be immune from civil liability for injury resulting from the self-administration of medications by the camper named above, and that the camper is agreeing to maintain the inhaler and not allow any other person to use it.

Signature of Legal Guardian ____ Date ________________________

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Attn: Camp Thrive
PO Box 948
Walworth, WI 53184-0948

Email: jmclafferty@InspirationRetreatCenter.org

Fax: (262) 275-3355

For Questions, call (262) 275-6131, Ext 222

Camp Thrive Health Certificate/Physician's Orders

The health care of every participant shall be under the supervision of a physician. The physician shall, prior to admission, certify that the participant has been examined within the last 24 months (90 days for residential applications). For the safety of your patient, please print and complete each line.

GENERAL INFORMATION

Patient/Camper Name: ____________________________________ Date of Birth: ______________________

Date of Physical Exam: _____________________________ (must be within the last 24 months)

Height: ___________________ Weight: _____________________ BP: ________________________

Date of last TB skin text or chest x-ray: ______________________ (required within 18 months) Date of last Tetanus shot: _________________________________

❒ I verity that the above-named participant is free from apparent communicable disease, including tuberculosis, and is detrimental to other participants.

Medical Diagnosis: ____

Significant past Medical History (include onset): ____

____

____

Past behavioral concerns: ____

Current treatment(s) at the time of this report: ____

____

MEDICATIONS (❒ check here if attaching a Plan of Service POS – **please have Physician sign and date**):

* Drug: ___________________________________
Dose/Schedule: ____________________________
Diagnosis: ________________________________

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Dose/Schedule: ____________________________
Diagnosis: ________________________________

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Dose/Schedule: ____________________________
Diagnosis: ________________________________

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Dose/Schedule: ____________________________
Diagnosis: ________________________________

* Drug: ___________________________________
Dose/Schedule: ____________________________
Diagnosis: ________________________________

* Drug: ___________________________________
Dose/Schedule: ____________________________
Diagnosis: ________________________________

OVER-THE-COUNTER (including vitamins, creams, etc.):

____

____

Enter camper last name here _______________ to ensure application file is complete

AMBULATION:

Participant may ambulate with appropriate assistive device and assist as needed: ❒ Yes ❒ No

Weight bearing status: ❒ Full ❒ as tolerated ❒ none

Describe any limitation or restriction on activities: ____

____

THE FOLLOWING PRNs MAY BE GIVEN:

❒ ___________________________ for pain ❒ ___________________________ for fever
❒ ___________________________ for indigestion ❒ ___________________________ for nausea
❒ ___________________________ for cough ❒ ___________________________ for skin irritation
❒ ___________________________ for constipation ❒ ___________________________ for diarrhea
❒ Antihistamine ❒ Decongestant ❒ Other _______________________________________

RECOMMENDATIONS, LIMITATIONS, CONTRAINDICATIONS:

____

____

____

I give my permission for the above-named participant to engage in Inspiration Ministries programs.

Physician Signature: ______________________________________ Date: ____________________________

Physician Printed Name (print or type): ____

Physician Address, City, State, Zip: ____

Physician Phone: (_______)________________________ Fax: (_______)_____________________________

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