FOR OFFICE USE ONLY

Date rec'd	_____________	Approved	_____________	Confirmation Sent	_____________
Amt. fee rec'd	_____________	Date rec'd	_____________	Paid by	_____________
	_____________		_____________		_____________

Must attach recent photo!

SEASONAL CAMP APPLICATION

MUST BE FULLY COMPLETED BEFORE CAMPER IS CONFIRMED.

Mail to: Easter Seals Camp ASCCA, P.O. Box 21, Jackson's Gap, AL 36861-0021 • (256) 825-9226 • 1-800-843-2267 (in Alabama only)
info@campascca.org • www.campascca.org

Camp ASCCA and Camp ASCCA Dadeville Campus are programs of the Easter Seals Alabama. This information is required for Camp ASCCA's use only in helping to make the applicant's camp experience positive and more enjoyable and will be held in the strictest confidence.

PLEASE PRINT OR TYPE Social Security Number: _______________________ Date of Birth: ___________________

I. IDENTIFYING INFORMATION

Last Name | First Name | Middle Name | Name Called | Sex | Age | Race

County | Camper's Address

City | State | Zip | (Area code) Home Phone | Email

Custody Status (Please check one) Independent ______________ Parent ______________ Other _________________________

Guardian Name | Address | City | State | Zip | (Area Code) Day Phone | Night/Cell Phone

Father's Name | Address | City | State | Zip | (Area Code) Day Phone | Night/Cell Phone

Mother's Name | Address | City | State | Zip | (Area Code) Day Phone | Night/Cell Phone

Grandparents' Name | Address | City | State | Zip | (Area Code) Day Phone | Night/Cell Phone

Father's place of employment ________________________________ Mother's place of employment _______________________________

Emergency Contact other than above – Name ____________________________________ Relationship _______________________________
Phone(s) (__________)____

Name and Address of camper's school, rehabilitation program or employer: ____
____

Has the camper attended Camp ASCCA or Camp ASCCA Dadeville Campus before? ___________________ When? ____________________
How did the camper find out about Camp ASCCA or Camp ASCCA Dadeville Campus? ____

II. NATURE OF DISABILITY (Please check all that apply)

_______ Asthma
_______ Attention Deficit Disorder
_______ Autism
_______ Cerebral Palsy (walks)
_______ Cerebral Palsy (wheelchair)
_______ Diabetes
_______ Head Injury
_______ Hearing Impaired
_______ Heart Condition
_______ Hemiplegia

_______ Multiple Sclerosis
_______ Muscular Dystrophy
_______ Seizure Disorder
_______ Shunt
_______ Sickle Cell
_______ Spina Bifida (walks)
_______ Spina Bifida (wheelchair)
_______ Spinal Cord (paraplegic)
_______ Spinal Cord (quadriplegic)
_______ Terminally Ill

_______ Learning Disabled
_______ Dyslexia
_______ Mildly Mentally Disabled
_______ Moderately Mentally Disabled
_______ Severely Mentally Disabled
_______ Non-disabled
_______ OTHER
_______ ______________________________
_______ ______________________________
_______ ______________________________

_______ Hemophilia _______ Visually Impaired _______ _______________________________

INCOMPLETE APPLICATIONS WILL BE RETURNED BEFORE PROCESSING AND DELAY YOUR ACCEPTANCE TO A SESSION!!

Last Name________________________ **First Name**________________ **Middle Name**________________ **Name Called**________________

III. PERSONAL HISTORY

To be completed by parent, guardian, or adult applicant. Indicate required assistance or level of involvement.

Approximate Mental Age Level ___________ Approximate Functional Age Level ___________ Height __________ Weight ___________

EATING: No assist ______ Partial assist ______ Total assist ______

DIET: Normal ______ Chopped food ______ Blended/Pureed ______
Low Calorie ______ Low salt ______ Low cholesterol ______
Diabetic ______ If diabetic, total number of calories ___________
Low-fat ______ Any other special diet ____

Does camper have any difficulty swallowing? ____
List problem foods or any food allergies. ____

HEARING: Normal ______ Hard of hearing ______ Partial loss ______ Total loss ______

SPEECH: Normal ______ Mildly affected ______ Moderately affected ______
Severely affected ______ Few words ______ Nonverbal ______

COMMUNICATION: Is the camper able to understand & communicate his/her needs to others…Ex. Food, thirst, bathroom, medical assistance? Yes ____ No ____
Camper makes his/her needs known by… Speaks ______ American Sign Language ______
Gestures ______ Communication Board ______ Other, please specify ______________________________

VISION: Normal ______ Partial loss ______ Legally blind ______ Total loss ______

MOBILITY: Walks ______ Crutches ______ Cane ______ Walker ______
Wheelchair (manual _____ electric _____) Other ____
Can the camper <u>independently</u> use his/her wheelchair? Yes _____ No _____
Does the camper currently have any skin breakdown or pressure sores? If so, please describe. ______________
____

TRANSFERS: No assist ______ Partial assist/Standby ______ Total assist ______

ADAPTIVE DEVICES: None ______ AFO's or night braces _____ Prosthesis ______ Helmet ______
Glasses ______ Contacts ______ Hearing Aid ______ Dentures ______
Other ____

TOILETING: Bladder Control: Normal/No assist ______ Occasional Incontinence/bed wetter ______
Partial assist ______ Total assist ______ Needs reminder ______

Bowel Control: Normal/No assist ______ Partial assist ______ Total assist ______

Aids used: None ______ Needs reminder ______ Urinal ______ Bedpan ______
Diapers ______ Toilet chair ______ Ostomy ______
Other, please specify ____

Catheterization: Self Cath/Independent ______ Dependent/Nurse ______ Indwelling Catheter ______
Condom Catheter ______
Catheter schedule ____

WASHING/BATHING: No assist ______ Partial assist ______ Total assist ______
Prefers: Shower ______ Tub Bath ______ Sponge Bath ______

DRESSING: No assist ______ Partial assist ______ Total assist ______

SLEEPING: Sleepwalks Yes _____ No _____ Needs to be awakened or turned during the night Yes _____ No _____

Can camper sleep on an upper bunk? Yes _____ No _____

Last Name________________________ **First Name**________________ **Middle Name**________________ **Name Called**________________

IV. MEDICAL INFORMATION – EVERY BLANK MUST BE COMPLETED!!

List all allergies (If **NO** allergies, please write "NONE") ____

____

Please list any problems (medical, behavioral or otherwise) of which we should be aware: ____________________________________

____

Has camper had any recent hospitalizations or illnesses? Yes __________ No __________ If yes, please explain _____________________

____

By signing this I agree to allow Camp ASCCA to administer any necessary over-the-counter medications and the below-prescribed medications to this camper. Guardian Signature: ____

Physician's Name: ____ Phone #: (_______)_______________
Address: Street ____________________________ City______________________ State __________ Zip ____________

MEDICATIONS: Please list all medication, dosages, and times medication is to be taken. ****ALL MEDICATIONS MUST BE SENT IN ORIGINAL PRESCRIPTION BOTTLES** OVER-THE-COUNTER MEDICATIONS MUST BE IN ORIGINAL BOTTLES****

Name of medication	Dosage (mg)	# of pills ea. time	Times to be taken (8a, 12n, 3p, 6p, 8p)

List any further medications on a separate sheet please. **IF NO MEDICATIONS TAKEN, PLEASE WRITE "NONE".**
** PLEASE NOTE: Camp nurses MUST be notified if the above medications change between the time application is submitted and the actual camp date. A copy of the physician prescription along with detailed and complete written instructions MUST accompany camper upon arrival to camp.

Camp ASCCA Staff provides routine health care to all campers, staff, volunteers, and visitors as necessary. Registered nurses deliver routine prescription medications on the following schedule…8a, 12n, 3p, 6p, 8p. Please call the Director of Health Services for any special considerations or concerns…800-843-2267 (in AL) or 256-825-9226.

V. INSURANCE INFORMATION

Insurance Coverage for accidents or illnesses while participating in programs at Camp ASCCA and/or Camp ASCCA Dadeville Campus is the responsibility of the camper and/or their family.

Please list your family health, accident, medical, or hospital insurance coverage.

CARRIER ____ POLICY OR GROUP NO. ____
MEDICARE NO. _____________________________________ MEDICAID NO. ____

**Every effort will be made by telephone to immediately notify parent or guardian of a camper illness, injury, accident, or behavior problem; hence the importance of providing the camp staff with phone numbers of your whereabouts during the camp session or a responsible party in your absence.

The Camp Director reserves the right to send the camper home if illness or other significant reason so dictates. If above named camper must be sent home and I cannot be reached, the following person has consented and has permission to care for the camper:

____
Name (Area Code) Phone(s)

____
Address

____
City State Zip

I hereby certify that all information given is true and complete. NAME, ADDRESS & PHONE OF ADULT RESPONSIBLE:

____
Name of Adult Guardian (Area Code) Phone(s)

____
Address

City State Zip

Signature of Adult Guardian Date

Application completed by: ____

CAMP ASCCA/CAMP ASCCA DADEVILLE CAMPUS MEDICAL CARE AND PUBLICITY CONSENT WAIVER FORM

I. MEDICAL RELEASE: MUST BE COMPLETED IN FULL AND RETURNED WITH APPLICATION

CAMPER NAME ____ SESSION _________________________________

I hereby grant permission to the Camp Physician or his authorized representatives to furnish or arrange for the furnishing of such hospital and/or medical care as __________________________ might require during such time as he/she is a resident of Camp ASCCA/Dadeville Campus.
(camper name)

This medical care shall include, but not be limited to, examinations, treatments, immunizations, injections, anesthesia, surgery, and other procedures, etc.

This permission is conditioned upon the understanding that in an event of serious illness or accident, or in the event of a need for hospital services and/or major surgery, said person will use all reasonable efforts to contact the undersigned. Failure in such efforts, however, shall not prevent the provision of emergency treatment necessary for the best interest of the life and health of the said.

This form may be photocopied. Camp ASCCA has permission to obtain a copy of the above camper's health record from the providers treating him/her. I understand that information about his/her health will be shared on a "need to know basis" with other medical providers/Camp ASCCA staff.

For and in consideration of said covenants, the camper and the undersigned hereby release, acquit, and covenant to hold harmless the said Camp Physician and all other persons, firms, and corporations from all claims, damages, and causes of action of whatever nature which may accrue to the said camper or the undersigned, their heirs, executors, administrators and legal representatives and assigns, arising out of any of the above procedures.

Signed (Parent or guardian) Print Name Date

Witness Print Name Date

Permission is also granted for said camper to be photographed, with such pictures and names to be used in public relations and fund-raising efforts to promote programs of Camp ASCCA, Camp ASCCA Dadeville Campus, and the Alabama Easter Seals Society of the Alabama Society for Crippled Children and Adults, Inc.

Signed (Parent or guardian) Print Name Date

Witness Print Name Date

II. PERSONAL INTERESTS (OPTIONAL)

In an effort to better meet the needs of our campers in the future, please list favorite:

Personal leisure and recreation activities and hobbies: ____