



2110 Hathaway Dr Brunswick OH 44212
Phone: 330-220-2112

Camp Registration Form
May 2, 2011

Name of Camper _____ Male Female

Camper's Address _____ Date of Birth: _____

Parent/Guardian _____ Phone: _____

Cell Phone: _____

Case Manager: _____ Phone: _____

EMERGENCY CONTACT

Contact Person: _____ Phone: _____

Relationship to Camper: _____ Cell Phone: _____

- Week 1 2011 Space Odyssey(June 6-10)
- Week 2 Mission Possible/CSI(June 13-17)
- Week 3 Life's Heroes(June 20-24)
- Week 4 "If I Ran The Zoo"(June 27-July 1)
- Week 5 Adventures in Photography(July 11-15)
- Week 6 Kreative Koncoctions(July 18-22)
- Week 7 Campers Got Talent(July 25-29)
- Week 8 Amazing Athletes(August 1-5)
- Week 9 Wet and Wild(August 8-12)

Amount of deposit \$ _____ (\$75.00 non-refundable deposit)

Indicate form of payment Check enclosed Family Resources Waiver

Person, agency or organization responsible for payment: _____

Address: _____

Return registration forms with deposit to :
Medina Creative Accessibility
Life Steps Camp
1120 North Huntington St.
Medina, Ohio 4425

Camp Registration – Continued

Camper's Name: _____

Please describe camper's disability/special needs: _____

Allergies: Please list all known allergies of camper

Medication Allergies:	Please describe reaction and management of the reaction:
Food Allergies:	
Other Allergies:	

Does Camper have any of the following?

___ Yes ___ No IEP or Behavior Plan

___ Yes ___ No Require communication assistance? List: _____

Explanation to enhance this camper's experience: _____

List some activities the camper enjoys, additional comments or suggestions:

Camp Medical Record
This is a required form – Due May 2, 2011
To Be Completed By A Physician

A completed form is required for all campers.

If the camper is taking prescription medication an exam must be performed within 12 months of arrival at camp. We will also accept a copy of another examination signed by camper's doctor if within these time frames.

Please Print Carefully:

Camper's Name _____

Date of Birth: _____ Age: _____

Please list **Allergies** if any: _____

Parent/Guardian: _____ Phone: _____

PHYSICIAN STATEMENT

Camper's Name _____

TETANUS SHOT CURRENT (Within last 10 years): Yes _____ No _____

Name of Physician prescribing medication: _____ Phone: _____

Camper is to take Medications while at Respite Camp as follows:

Name of Medication	Dosage and Frequency	Dispensing Method

Medical Diagnosis: _____

Please list all health concerns that staff should be aware of: _____

I certify the above applicant is fit to participate in the Respite Camp program and is free of communicable disease:

Physician Signature: _____ **Date:** _____

APPROVED PRN FORM

TO BE COMPLETED AND SIGNED BY A PARENT OR GUARDIAN

Camper's Name: _____ Date: _____

Allergies: _____

Approved PRN Medications:

SYMPTOM	MEDICATION	DOSAGE
Headache, Pain, Fever	Acetaminophen	Per product recommendation on campers age and weight
Muscle aches, menstrual cramps	Ibuprofen	Per product recommendation on campers age and weight
Nasal Congestion	Sudafed	Per product recommendation on campers age and weight
Sore Throat	Chloraseptic	Per product recommendation on campers age and weight
Stomach Ache, Indigestion	Pepto Bismol	Per product recommendation on campers age and weight
Sun Protection	Sun Block SPF #30	Per product recommendation on campers age and weight
Sunburn	Americaine Spray	Per product recommendation on campers age and weight
Dry Skin	Moisturizing Lotion	Per product recommendation on campers age and weight
Cuts, Abrasions	Hydrogen Peroxide Bacitracin Ointment	Per product recommendation on campers age and weight

Parent or Guardian Signature: _____ Date: _____

**LIFE STEPS Camp
Consent Form**

Camper's Name: _____

Yes No I authorize Life Skills Respite Camp to act for me in a responsible manner in case of an emergency that requires medical care.

Yes No I authorize the Camp Director or authorized MCL staff to administer the campers medication as listed on their medical form.

Yes No I give permission for camp staff to transport camper for outings and activities.

Yes No I give MCA permission to photograph or video tape Camper while they are engaged in activities involved with camp. I also give permission for the public dissemination of this material for education and promotional purposes.

I authorize the following individuals listed to pick up my camper.

Parent or Guardian Signature _____ Date: _____

ACTIVITIES OF DAILY LIVING FORM - DUE May 2, 2011 CAMPER'S

NAME: _____ **DATE:** _____

Please be as specific as possible:

EATING/DRINKING:

- Independent
- Difficulty swallowing
- Needs food cut up and special plate or utensil (list)
- Must be fed
- Can use straw

Explain: _____

DIET:

- Normal
- Low salt
- Low calorie – Total calories _____
- Diabetic – Total calories _____
- Knows limits
- Chopped food
- Blended/pureed food

List food restrictions: _____

List food allergies: _____

SWIMMING:

- Requires Life Jacket or Floatation Device

MOBILITY:

- Walks independently
- Walks: Needs assist w/ slopes, rough areas
- Wheelchair: Independent
- Wheelchair: Assist w/ slopes, rough areas
- Wheelchair: Needs assist at all times
- Wheelchair: Long distances only
- Requires rest during the day

TRANSFERS:

- Camper weighs: _____ lbs.
- Can make independently
- Pivot transfers/can bear weight on feet
- Must be lifted *

Please explain: _____

* must provide own hooyer, if needed.

DRESSES/UNDRESSES:

- Independent
- Needs partial assistance
- Needs total assistance

Explain: _____

BATHING:

- Independent
- Needs partial assistance
- Needs total assistance
- Uses shower
- Uses shower chair

Explain: _____

BATHROOM:

- Independent
- Bladder incontinence
- Bowel incontinence
- Requires prompting for toileting
- Needs transfer to toilet
- Needs assistance wiping
- Needs total assistance
- Uses toilet chair
- Uses special undergarments
- Requires assistance with menstrual care

ADAPTIVE EQUIPMENT:

- Glasses
 - Contacts
 - Hearing Aid
 - Dentures
 - Other
- (list) _____

