

## CAMP 4:13 GENERAL INFORMATION keep this page

Dear Applicant/Legal Guardian:

Please use the following checklist to complete your application.

- Have you read the entire application?
- Have you completed the application and attached any additional information you consider pertinent?
- Have you attached a picture of the applicant with name clearly marked as requested? (no larger than 4"x6")
- Have you included the required \$100 non-refundable deposit, or full payment?** Any balance is due upon arrival. Only send exact tuition amounts please.
- Have you included a copy of your Medical Assistance and/or Medicare card?
  
- Have you included all the application pages together? **GUARDIAN AND PHYSICIAN SIGNATURES MUST BE ORIGINALS. Incomplete applications cannot be processed.**
  
- Has your physician completed and signed the Medical Form of the application?  
**ALL APPLICANTS MUST HAVE A MEDICAL EXAMINATION** within twelve months prior to the date of CAMP 4:13. Each applicant must present a current **HEALTH** history as part of this application. Substitutions of this form will not be accepted, however additional information is appreciated. **All medications must be in original prescription bottles clearly marked for content, dosage, and frequency.** All medical and behavioral incidents will be documented. Applicants over 50 lbs, needing transfers should expect to be lifted with the help of mechanical assistance which you must provide. Behavioral, food, etc. charting will not be done. Only medication charting will be recorded. Camp 4:13 programming takes precedence over any individual planned programming.

**APPLICANTS UNDER THE AGE OF 10** must be accompanied by a parent/guardian. A spouse or parent/guardian providing applicant's care may accompany him/her at no charge.

If you are **PROVIDING YOUR OWN CAREGIVER**, their completed staff application must be submitted with yours.

**ACCEPTANCE** to Camp 4:13 is not guaranteed. We reserve the right to refuse acceptance of applicant based on our ability to provide adequate care in conjunction with applicants needs with regard to our programming. Pre-registration is required. An acceptance letter will be mailed two weeks prior to the date of Camp. If applicant is not accepted, a full refund will be given.

**REGISTRATION** begins on Monday, July 30th at 1:00pm and ends at 2:30pm. Camp concludes at 1:00pm on Friday, August 3rd. Grounds must be cleared by 2:00pm. Be sure your transportation is punctual.

**TRANSPORTATION** to and from the grounds is the applicant's responsibility.

# 2012 Camp 4:13 Camper Application

Incomplete applications cannot be processed and will be returned

MAIL COMPLETED APPLICATION WITH GUARDIAN SIGNATURE, PHYSICIAN'S SIGNATURE AND DEPOSIT TO:  
**ARKANSAS DISTRICT A/G CAMP 4:13; PO Box 191670; Little Rock, AR 72219-1670**  
For more information email: andhouse@aol.com • 479-549-7070

A NON REFUNDABLE \$100 DEPOSIT MUST BE INCLUDED- make check payable to Arkansas District A/G & NOTATE "CAMP 4:13"

Applicant Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
(if different from first name)

Applicant's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Age \_\_\_\_ (Applicant must be over 10 or a parent must attend as caregiver staff)

Foster Home  Institution  Live in own home/apt  Live with parent/guardian

Residential Facility/Group Home Name \_\_\_\_\_

I am my own Guardian **If not, Name of Legal Guardian** \_\_\_\_\_

Relationship \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Day (\_\_\_\_) \_\_\_\_\_ Evening (\_\_\_\_) \_\_\_\_\_

## Emergency number different than guardian:

Name \_\_\_\_\_ Relationship to applicant \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Home Church \_\_\_\_\_ City \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_



# SKILL EVALUATION *continued*

## EATING

- Independent - needs no assistance
- Needs assistance with \_\_\_\_\_
- Dependent, must be fed (Please provide a week's supply of disposable bibs & straws if needed)
- Has difficulty swallowing solids liquids must use straw (Please send supply for week)
- Appetite large medium small limit helpings

Allergic to foods listed: \_\_\_\_\_

Diet restriction that CANNOT lapse during camp: \_\_\_\_\_

*(We are unable to provide specialized charting or diet for each applicant due to a camp type environment. If you cannot be tolerant in this area, YOU must provide special dietary foods i.e.: sugar free food and drink. Refrigeration and special preparation of food is NOT available.)*

## COMMUNICATION

- No Difficulty
- Has difficulty
  - expressing self
  - Understands directions and prompts
  - Slow to communicate needs
  - Difficulty understanding directions
  - Uses gestures
  - Non-verbal Uses sign language (Please attach a description of signs)
  - Uses own language board (Please send with applicant)
- Comments \_\_\_\_\_

## BEHAVIOR

- Generally happy (check all that apply) Compliant Social Helpful Cooperative
- Generally unhappy (check all that apply) Non compliant Withdrawn Prone to depression
- Does well in large groups Does NOT do well in large groups
- Cautious/Shy Wanders (Note: applicant who wanders off may be sent home for safety)
- Physically Abusive/Aggressive to self to others to staff
- Adapts to new environment Quickly Slowly
- Autistic Behavior - describe: \_\_\_\_\_
- Other behaviors - Explain \_\_\_\_\_
- Are there any behavior problems you handle in specific ways and would like us to continue? \_\_\_\_\_

*We ask this because we will try to be consistent with expectations and discipline at home. Verbal instructions are inadequate.*

## SELF CARE & DRESSING

- Independent - needs no assistance
- Assistance is needed because applicant is: slow needs prompts
- Cannot dress self without assistance Please explain: \_\_\_\_\_
- Totally dependent
- Needs help with personal hygiene Describe assistance needed: \_\_\_\_\_
- Usual bedtime \_\_\_\_\_ Usually awakens at \_\_\_\_\_
- Special Sleeping Habits \_\_\_\_\_
- Written instructions for specific care needs are listed on a separate page.

## TOILET NEEDS - Send adequate for needs.

**You MUST bring your own shower/toilet chair if needed**

- Independent - needs no assistance
- Needs assistance with \_\_\_\_\_
- Totally Dependent Catheter Colostomy
- Uses Depends/Diapers at all times only at night (Bring enough for the entire week)
  - Incontinent: Bowel Bladder (Depends will be used)
- Wets Bed (Supply adequate bedding, clothing, and/or Depends as laundry is not done during camp)
- Female guest is able to care for self during menstruation:
  - Fully Partially Not at all Expected during week

## ACTIVITIES

- Independent - needs no assistance
- Needs assistance in some activities: Arts/Crafts Sporting/Recreation
- Dependent for all activities
- Water Sports: Not allowed Swims shallow Swims deep
  - Uses flotation Does not swim Afraid of water
- Activities applicant enjoys \_\_\_\_\_
- Recreational activity applicant cannot participate in: \_\_\_\_\_

## Camp 4:13 Camper APPLICATION RELEASE FORM

I give permission as legal guardian for the applicant to attend Camp 4:13. To the best of my knowledge, all signatures and information in the Application 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 the Arkansas District Camp reserves the right to reject any applicant whose needs cannot be met by staff.

I understand that due to specific state laws and Arkansas District Camp policy, ALL medications, whether prescription or non-prescription, brought to Camp MUST be in 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 if medication, prescribing physician and pharmacy are identified. Applicant will not be allowed to stay if this is not followed.

In the event I cannot be reached in an EMERGENCY, I give permission to the Health Care Professional selected by the Arkansas District Camp staff to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery. I will assume financial responsibility for any medical treatment not covered by Arkansas District insurance.

If applicant displays inappropriate behavior, which causes dismissal, the legal guardian, or current home assumes immediate responsibility for transportation and its cost to return applicant home. No refunds will be given.

I agree not to send applicant if exposed to a contagious disease within three weeks of the event, and I will notify Arkansas District Camp if applicant must cancel. No one will be denied attendance at Camp because of religion, creed, national origin, sex, age, or disability.

I release and hold harmless Arkansas District Camp, its board of directors, staff, leadership, and volunteers, from liability due to negligence by Arkansas District staff or volunteers. I shall bring no claims, demands, or litigation against Arkansas District Camp for losses due to bodily injury, death, or property damage arising out of or related to participation at Camp 4:13.

I understand that individuals are prohibited from carrying any weapon, as defined by state and local law, and including, but not limited to; handguns, firearms, "electric weapons" identified as any device which is used or intended to be used to immobilize or incapacitate persons by the use of electric current, a knife, a Billy club, or any other implement that is fashioned, designed, or intended to be used as a weapon, at any Arkansas District Camp events. I also realize that tobacco, alcohol and drugs (except those administered by Medical Staff) are not allowed at Camp 4:13.

Permission is given to Arkansas District Camp to use photographs (individual or group) and/or multi-media images and recordings made or obtained.

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 a Arkansas District Camp 4:13.

Parent/ Legal Guardian Name: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Signature of Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

*Or Applicant Signature if own legal guardian*

*(Applications cannot be processed without proper signatures)*

A CONFIRMATION OF ACCEPTANCE WILL BE SENT NO LATER THAN TWO WEEKS PRIOR TO CAMP

**2012 MEDICAL FORM** No substitutions of this form will be accepted All applicants must have a medical examination within twelve months prior to date of Get Away applying for.

PLEASE PRINT

Medical History for (Applicant's name) \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Medical diagnosis of disability: \_\_\_\_\_

Explanation/Onset/Cause of disability: \_\_\_\_\_

Applicant's current health condition: \_\_\_\_\_

Operations/Serious Illness—Dates & Description: \_\_\_\_\_

Chronic/Recurring Illness: \_\_\_\_\_

Applicant has seizures:

No  Yes - Frequency \_\_\_\_\_ Date of last seizure \_\_\_\_\_ Controlled by medication:  No  Yes

Describe seizure \_\_\_\_\_

Activities applicant should not participate in \_\_\_\_\_

**ALLERGIES**

Penicillin  Aspirin  Latex  Hay Fever

Food Allergy: \_\_\_\_\_  Other: \_\_\_\_\_

**DISEASES/PAST ILLNESS**

Diabetes  Asthma  Chicken Pox  Tuberculosis  Other: \_\_\_\_\_

**IMMUNIZATIONS**

Up to date:  yes  no

Tetanus Date \_\_\_\_\_  HBV Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_ Date 3 \_\_\_\_\_

For Applicants 18 Years & Under Enter month & year of each immunization

DPT/DT/TD Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_ Date 3 \_\_\_\_\_ Date 4 \_\_\_\_\_ Date 5 \_\_\_\_\_

POLIO Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_ Date 3 \_\_\_\_\_ Date 4 \_\_\_\_\_ Date 5 \_\_\_\_\_

MMR Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_ Date 3 \_\_\_\_\_ Date 4 \_\_\_\_\_ Date 5 \_\_\_\_\_

HBV Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_ Date 3 \_\_\_\_\_ Date 4 \_\_\_\_\_ Date 5 \_\_\_\_\_

**MEDICATION:** ALL MEDICATIONS MUST BE IN THE ORIGINAL PRESCRIPTION BOTTLE MARKED FOR CONTENT, DOSAGE, AND FREQUENCY

MEDICATION NAME

DOSAGE

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Adverse reactions from medications: \_\_\_\_\_

**PHYSICIAN PERMISSION**

I have examined the person herein described and have reviewed their health history. It is my opinion that they are physically able to engage in Camp 4:13 functions through the end of the calendar year, except as noted above.

Physician's Name \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

*RN, LPN, QMRP signatures are NOT acceptable.*

Physician's Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

MAIL COMPLETED APPLICATION WITH GUARDIAN SIGNATURE, PHYSICIAN'S SIGNATURE AND DEPOSIT TO:  
ARKANSAS DISTRICT A/G CAMP 4:13; PO Box 191670; Little Rock, AR 72219-1670