

FOR OFFICE USE ONLY

Date Received \_\_\_\_\_ Amount Received \_\_\_\_\_  
Check Number \_\_\_\_\_ Approved By \_\_\_\_\_

## OceanBay Camper Application & Medical Record

### July 8th - July 13th, 2018

In order for an application to be considered complete, the Physician Papers and an Application Deposit of \$250.00 is required. If accepted, the Application Deposit will be credited toward the Campers Tuition. If we are unable to accept the applicant for any reason, the Application Deposit will be returned in full.

#### CAMPER INFORMATION

Camper's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
( ) Male ( ) Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Type of Residence: ( ) Private Home ( ) Group/Assisted Living Home ( ) Institution ( ) Other  
Has the Camper ever attended Oceanwood or Grotonwood? ( ) No ( ) Yes - When? \_\_\_\_\_

#### CONTACT INFORMATION (While at Camp & During the Year)

Parent/Guardian #1: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Alt: \_\_\_\_\_  
Relationship to Camper: \_\_\_\_\_ Email: \_\_\_\_\_

#### If Not Available, Please Call:

Parent/Guardian #2: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Alt: \_\_\_\_\_  
Relationship to Camper: \_\_\_\_\_ Email: \_\_\_\_\_

#### Person/Agency Responsible for Transportation

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Alt: \_\_\_\_\_

#### INSURANCE INFORMATION & REQUEST FOR YEARLY PHYSICAL\*

Insurance coverage for accidents or illness while participating at Oceanwood are the responsibility of the Camper and/or their family. **Please include a copy of your current insurance card.**

Carrier: \_\_\_\_\_ Policy or Group No. \_\_\_\_\_  
Medicare / Medicaid No. \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_  
Address of Carrier: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**\*A CURRENT PHYSICAL (WITHIN THE PAST 12 MONTHS OF THE CAMP START DATE) IS REQUIRED FOR PARTICIPATION AND ACCEPTANCE INTO OCEANWOOD PROGRAMMING\***

### ABILITIES LIST

OceanBay programming is based on a 1:4 staff to camper ratio. Daily activities run from 8am - 9pm. All activities are supervised and assisted by the Disabilities Staff. **All campers must meet the following Abilities List** in order to participate

**Mobility:** ( ) Must be able to navigate semi-rough terrain with assistance of a walker or Staff assistance.

**Medical Conditions:** ( ) Seizure Disease / 1 or less a month ( ) Able to eat most adult table foods

**Self-Help Skills:** ( ) Uses toilet appropriately with minimal to moderate assistance. - Incontinent campers must be willing to wear protective undergarments & come supplied with enough for camp. ( ) Capable of washing, dressing, and eating with assistance. ( ) Women should understand/be aware of their menstruation cycle.

**Social Skills:** ( ) Able to communicate needs either verbally or non-verbally. ( ) Able to relate appropriately to other campers and leadership in a structured program. ( ) Able to participate in program activities, included but not limited too; swimming, archery, horsemanship, etc. ( ) Able to stay within physical boundaries of the camp setting with no wandering and remain with the group. ( ) Free from any self-abusive or aggressive behaviors.

**Please be aware of the abilities list to decide if the camper is appropriate for the program. If you have any questions, please contact the office at 207-934-9655 or email office@oceanwood.org to discuss your questions or concerns.**

**I have read the above abilities list and this camper meets the listed requirements.**

\_\_\_\_\_  
Signature of Camper or Parent/Guardian/Caregiver

\_\_\_\_\_  
Date

### UNDERSTANDING THE CAMPER

Primary Diagnosis: \_\_\_\_\_ Degree of Developmental Delay: \_\_\_\_\_

Physical Disability: \_\_\_\_\_

Does the Camper have: ( ) Autism ( ) Cerebral Palsy ( ) Epilepsy ( ) Diabetes ( ) Seizure Disorder  
( ) ADHD/ADD ( ) Visual Impairment ( ) Mobility Impairment ( ) Hearing Impairment ( ) Other: \_\_\_\_\_

Please provide any treatment, protocols followed, or any other information on checked items:

Please check if the Camper is subject to any of the following:

- ( ) Sunburn ( ) Urinary Infections ( ) Bedwetting ( ) Constipation ( ) Diarrhea ( ) Vaginal Infections  
( ) Sinus Infection ( ) Bronchitis ( ) Pneumonia ( ) Frequent Colds ( ) Ear Infection ( ) Sore Throat  
( ) Asthma ( ) Dizziness/Fainting ( ) Nausea/Vomiting ( ) Anxiety ( ) Panic Attacks ( ) Skin Rash  
( ) Back Problems ( ) Joint Problems ( ) Hernia ( ) Frequent Headaches ( ) High Blood Pressure  
( ) Chest pain during/after exercise ( ) **Medication Allergies:** \_\_\_\_\_

( ) **Food Allergies:** \_\_\_\_\_ ( ) **Other Allergies:** \_\_\_\_\_

Reaction to any listed allergens: \_\_\_\_\_

**\* Is Camper required to carry an EPI pen?** ( ) No ( ) Yes - **Please pack & Provide Dr. Note**

**\* Is Camper required to carry an inhaler?** ( ) No ( ) Yes - **Please pack & Provide Dr. Note**

Camper **must:** ( ) **Not** get water in ears ( ) Stay **out** of water ( ) Wear ear plugs when swimming

Has the Camper: ( ) Been hospitalized ( ) Ever had surgery ( ) Ever had a head injury

Please comment on the above checked items & pack anything required for treatment/management:

### MORE ABOUT THE CAMPER

**Camper's Speech:** ( ) Normal ( ) Mildly Affected ( ) Moderately Affected ( ) Few Words ( ) Non-Verbal

Can Camper communicate their wants/needs? ( ) No ( ) Yes

Method of communication: ( ) Verbal ( ) Sign Language ( ) Points/Grunts

Does Camper understand/respond to yes/no questions? ( ) No ( ) Yes

Is Camper able to communicate pain? ( ) No ( ) Yes

Please list any further communication instructions and assistance required: \_\_\_\_\_

**Camper's Hearing:** ( ) Normal ( ) Hard of Hearing ( ) Partial Loss ( ) Total Loss ( ) Wears Hearing Aids

If Camper has partial or total loss, please explain the best way to communicate with the camper: \_\_\_\_\_

**Camper's Memory:**            **NO**            **YES**

Oriented to place?        ( )        ( )

Oriented to time?        ( )        ( )

Follows directions?      ( )        ( )

Please explain any "no's" or provide information on how to best help the camper adjust the the daily schedule of camp: \_\_\_\_\_

**Does the Camper require assistance in walking?** ( ) No ( ) Yes

Can Camper walk up/down stairs unaided? ( ) Yes ( ) No - Explain: \_\_\_\_\_

Camper's gait: ( ) Stable ( ) Walks Slowly ( ) Falls Easily ( ) Unsteady

Does the Camper use: ( ) Support from another person ( ) Cane ( ) Walker ( ) Crutches

( ) Other: \_\_\_\_\_

**Does Camper have a history of seizures?** ( ) No ( ) Yes - Date of last seizure: \_\_\_\_\_

Type(s) of seizures: \_\_\_\_\_ How many in past 6 months? \_\_\_\_\_

Duration of seizure: \_\_\_\_\_ Known triggers: \_\_\_\_\_

Behavior before: \_\_\_\_\_

During: \_\_\_\_\_

After: \_\_\_\_\_

Please provide any post seizure protocol normally followed: \_\_\_\_\_

**Does Camper have diabetes?** ( ) No ( ) Yes - How is it controlled & is blood testing required? \_\_\_\_\_

### ADAPTIVE DEVICES

Please check off and **send** any adaptive devices the Camper uses on a regular basis:

- ( ) None ( ) Helmet ( ) Hearing/Communication Aids ( ) AFO's or Braces ( ) Glasses/Contacts ( ) Chucks  
 ( ) Walker ( ) Cane ( ) Dentures ( ) Utensils ( ) Catheter ( ) Nebulizer ( ) Pacemaker  
 ( ) Compression Socks ( ) Prothesis ( ) Wound Management Materials ( ) Protective Undergarments  
 ( ) Other: \_\_\_\_\_

Please provide any specific instructions on use and care of any adaptive devices:

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### RESTRICTIONS & RECOMMENDATIONS WHILE AT CAMP

List any Dietary Restrictions, Medically-Prescribed Meal Plans, or any Special Diets (gluten-free, low salt, etc):

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Camper **does not** eat: ( ) Beef ( ) Seafood ( ) Eggs ( ) Pork ( ) Dairy Products ( ) Other: \_\_\_\_\_

Eating assistance level: ( ) Independent ( ) Self Feed Finger Foods ( ) Minimal Help ( ) Cannot self feed

Please list any assistance, \*special utensils or supplements required, & difficulties with eating: **\*please bring**

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### ACTIVITIES

ACTIVITIES	GOOD TO PARTICIPATE	CANNOT PARTICIPATE	SOME ASSISTANCE REQ	MODERATE ASSISTANCE REQ
<b>SWIMMING</b>				
<b>BEACH ACTIVITIES</b>				
<b>HIKING</b>				
<b>HORSEBACK RIDING</b>				
<b>ARCHERY</b>				
<b>TEAM SPORTS</b>				

List any **restricted** activities: \_\_\_\_\_

List any activities the Camper **enjoys**: \_\_\_\_\_

List any activities the Camper **dislikes**: \_\_\_\_\_

Please provide any other information you feel staff should know about the Camper:

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**BEHAVIOR & PEER RELATING**

Check the behaviors that apply to the Camper

- No unusual behavior     Physically aggressive towards others     Verbally aggressive
- Shy/Withdrawn     Stubbornness     Self-Injurious     Wanders/Runs Off
- Attaches to **male** staff     Attaches to **female** staff     Outbursts     Unwilling to Participate
- Repetitive Behaviors - What? \_\_\_\_\_  Other: \_\_\_\_\_

Explain any checked behaviors, their frequency, & method/interventions of dealing with the behaviors:

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Is the Camper on a behavior management plan?  No  Yes - Please attach a copy of the program

List any strong fears for the Camper and method to deal with the fear (animals, thunder, water, etc.):

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Please list any other information you feel would be helpful in providing the best experience for this Camper:

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**PERSONAL CARE**

Camper's sleeping patterns:  Normal  Restless  Hard to wake  Talks in sleep  Sleepwalks  
 Does the Camper need bedrails?  No  Yes      Does the Camper need a nightlight?  No  Yes  
 Please provide average hours of sleep time for the Camper & any bedtime rituals:

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Does the Camper need assistance with Grooming & Dressing?  No  Yes - Please describe help needed-

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How independent is the Camper with showering?  No Assistance  Little Assistance  Total Assistance

Explain - \_\_\_\_\_

Is bathroom assistance needed?  No  Very little assistance  Total Help

Does Camper wear Attends/Briefs during the day?  No  \*Yes    At night?  No  \*Yes **\*Please Provide**

Please bring any of the following items if needed:  Urinal  Bedpan  Catheter -Type: \_\_\_\_\_

Is Camper on any bathroom schedule?  No  Yes - Describe: \_\_\_\_\_

Please provide any further information on Camper's personal care for the staff to know:

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**Enclosed is my Application Deposit** (\$250.00 Required) of \$\_\_\_\_\_. **(Deposit goes toward tuition of \$995.00)**

An additional \$\_\_\_\_\_ is included as a donation to help provide scholarship & resources to Oceanwood Programming

**Please make checks payable to OCEANWOOD**

**Credit cards may also be taken over the phone, please call the office**

If the Camper's Tuition is being paid for by an agency please provide the following:

Agency Name: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Amount Contributed: \_\_\_\_\_

**I understand that the Application Deposit is non-refundable, non-transferable; and that the tuition costs for campers that leave prior to the end of their camp session will be pro-rated and refunded only in the case of illness or injury.**

### Waiver & Release

This document **must be signed by either the Camper or parent/legal guardian.**

**As a condition to participation in Oceanwood programming, the Camper agrees to the following:**

- Camper acknowledges that a wide variety of activities will be conducted.
- Camper acknowledges that some activities may subject them to stresses or hazards not foreseen.
- Camper consents to participate to some degree in all activities unless noted in writing prior to camp.
- Camper assumes all risks involved with activities & agrees that Oceanwood, nor its representatives be held responsible for any damages or injuries to the Camper.
- Camper understands that Oceanwood reserves the right to dismiss any Camper from the program in the event that staff determine the Camper cannot meet the program eligibility requirements.
- Supervision and transportation resulting from dismissal are the responsibility of the Camper.
- Camper understands that **no** refund will be given if dismissed for behavioral reasons.
- Camper understands that Oceanwood or its representatives are not responsible for loss or damage to personal belongings.
- Camper is liable for any damage to Oceanwood property as a result of the Campers actions.
- Camper consents to the use of photographs or video taken during the program for marketing, promotion, or social media use by Oceanwood, unless otherwise indicated in writing prior to the start of camp. Camper waives all claims of compensation for such use of photographs or video.
- Permission is granted for Camper to attend all program field trips upon notification.
- Camper represents that all information provided on this application, including but no limited to health/medical information to be true and accurate. Oceanwood and its representatives can be assured that they can rely on the information contained with in the application.
- Camper further recognizes that Oceanwood and its representatives reserve the right to reject any Camper in the event of the Campers refusal or failure to accurately complete and sign all required documents within any set time frames by Oceanwood or its representatives.

**I have read and fully understand the program details, waiver & release.**

**Signature of Camper 18yrs or older:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Parent/Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**MEDICATION GUIDELINES**

**Please read and sign below, even if the Camper takes no medications**

It is vitally important that all **prescribed medications** are brought to camp in **blister packs\*** from the **pharmacy**, with the **camper's name** and **doctor's name** clearly visible on the label. Campers **will not be permitted to stay** if medications are re-packaged in any type of container. All medications will be administered according to the dosage instructions as expressed on the prescription. While at camp, **all medications are administered by the camp medical staff**, with the exception of prescription creams, shampoos, or oral rinses. **Absolutely no peanut products are allowed at camp.**

- \* **I have reviewed the completed Camper Application & Medical Record. It is correct and complete, and the Camper described within has permission to engage in all activities except noted.**
- \* **I give permission to the camp medical staff and/or physician to administer any necessary first aid should a situation arise requiring medical attention while at Oceanwood.**
- \* **In case of an emergency, I give permission to the physician selected by the camp director in conjunction with the camp medical staff to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery.**
- \* **I give permission to the camp medical staff to administer prescriptions (as noted below) and over the counter (OTC/PRNs) brought to camp.**
- \* **I will notify Oceanwood and its medical staff of any medication changes made between the time application is submitted and the start of camp. I will provide a copy of the physician prescription along with the complete detailed instructions with the Camper upon arrival to camp.**
- \* **I WILL PROVIDE A CURRENT (WITHIN THE PAST 12 MONTHS OF THE CAMP START DATE) PHYSICAL WITH ANY MEDICATION INFORMATION TO OCEANWOOD NO LATER THAN 3 WEEKS PRIOR TO CAMP - FAILURE TO DO SO COULD RESULT IN A LOSS OF ACCEPTANCE INTO THE PROGRAM AND RESULT IN THE DENIAL TO REFUND THE APPLICATION DEPOSIT**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICATION RECORD**

**This Camper does not take any medications on a routine basis and comes to camp with no medications.**

Drug Name Exactly as Dispensed	Dosage & How its Administered	Time(s) & Day(s) Given	Reason(s) for Medication

**PLEASE SUPPLY ANY ORAL SYRINGES, MED SPOONS, OR APPLESAUCE FOR MEDICATION ADMINISTRATION IF NEEDED**

## NOTICE OF MEDICATION PACKAGING CHANGE

### **\*Pharmacy Blister Packs - Medications**

Effective Summer 2018, Oceanwood Camp will be moving to a pharmacy packaged blister pack medication administration system. Pharmacy blister packs will group all medications for each med pass and all prescriptions are included in the pack. It also ensures safe, accurate and timely administration of your camper's medications. Medications that are excluded from this include liquids, birth control, Coumadin and Prednisone. We understand this is a new system, but we feel confident it is the safest way to give campers their medications. Please contact your current pharmacy to inquire about this service. You can also visit [campmeds.com](http://campmeds.com) as this company is used by many camps. Please do not send over the counter medications as our health office is stocked with everything your camper needs.

If you have any questions please contact the office at (207)934-9655 or email [office@oceanwood.org](mailto:office@oceanwood.org)





## PHYSICAL EXAMINATION

Please be accurate & up-to-date within the previous 12 months to the Camper's session date.  
Physical examination form must be completed & signed by a LICENSED PHYSICIAN or attach the Physicians Form

Camper Name: \_\_\_\_\_ Session Dates: \_\_\_\_\_

Height: _____	Weight: _____	Pulse: _____	Temp: _____
BP: _____	Head/Scalp: _____	Skin: _____	
Lungs: _____	Cardiac: _____	Hearing: _____	
Eyes: _____	Vision: _____	Mouth/Throat/Nose: _____	
Neck/Thyroid/Lymph Sys: _____		Nervous Sys: _____	
Upper Extremities: _____		Lower Extremities: _____	
Back/Spine: _____	Perineum: _____	Abdomen: _____	
Breast Exam: _____	PAP Smear: _____	Testes Exam: _____	

VACCINATIONS	<u>PROBLEMS:</u>	<u>PAST</u>	<u>PRESENT</u>	<u>EXPLAIN:</u>
Tetanus/Diphtheria Booster: _____	Tuberculosis	( )	( )	_____
Rubella Vaccine: _____	Hepatitis B	( )	( )	_____
Mumps (DOB after 1956): _____	Bleeding	( )	( )	_____
Measles (DOB after 1956): _____	Rheumatic Fever	( )	( )	_____
Date of last TB Mantoux Test: _____	HIV Positive	( )	( )	_____
Results: ( ) Positive ( ) Negative	Heart Disease	( )	( )	_____
	Other: _____	( )	( )	_____

ACTIVITY RESTRICTIONS
List any conditions, operations or known serious injury that may effect activity level: _____ _____
Any restrictions to participate in Swimming? ( ) No ( ) Yes - Explain: _____ _____
Any restrictions to participate in Horseback Riding? ( ) No ( ) Yes - Explain: _____ _____
Please list any other activity restrictions: _____ _____

Examining Physician: _____	Date: _____
Signature: _____	Practice Name: _____
Address: _____	Phone #: _____