FOR OFFICE USE ONLY

Date Received __________ Amount Received ___________

Check Number __________ Approved By ______________

OceanBay Camper Application & Medical Record

July 5th - July 10th, 2020

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:

____

____

____

RESTRICTIONS & RECOMMENDATIONS WHILE AT CAMP

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

____

____

____

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**

____

____

____

ACTIVITIES

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

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:

____

____

____

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:

____

____

____

____

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.):

____

____

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

____

____

____

PERSONAL CARE

Campers 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:

____

____

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

____

____

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 Campers personal care for the staff to know:

____

____

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 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

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

Tetanus/Diptheria Booster: __________

Rubella Vaccine: __________

Mumps (DOB after 1956): ___________

Measles (DOB after 1956): ___________

Date of last TB Mantoux Test: _________

Results: ( ) Positive ( ) Negative

PROBLEMS:	PAST	PRESENT	EXPLAIN:
Tuberculosis	( )	( )	________________________
Hepatitis B	( )	( )	________________________
Bleeding	( )	( )	________________________
Rheumatic Fever	( )	( )	________________________
HIV Positive	( )	( )	________________________
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 #:** _______________________