

# OceanBay & Adventure Camper Application & Medical Record

## Monday, July 5th - Friday, July 9th

In order for an application to be considered complete, the **medical forms** and **application deposit** of \$250.00 is required. If accepted, the application deposit will be credited toward the camper's tuition. If we are unable to accept the applicant, or if the session cannot run as planned, the 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 ( ) Other

Has the Camper ever attended Oceanwood or Grotonwood? ( ) No ( ) Yes - When? \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Contact #1: \_\_\_\_\_ Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_ Email: \_\_\_\_\_

#### If Not Available, Please Call:

Contact #2: \_\_\_\_\_ Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_

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 AT OCEANWOOD PROGRAMMING\***

**CAMPER CRITERIA** (Please review and check each applicable box)

Daily activities run from 8am - 8pm. All activities are supervised by our trained & caring staff and modified appropriately.

**Below is a list of criteria campers should meet to be able to have a safe and successful camp experience. Please read through and check each box if it applies. Please explain below if any box is unchecked.**

**Mobility:** ( ) Must be able to navigate outdoor terrain independently or with minimal assistance, such as a cane or walker.

**Medical Conditions:** ( ) Seizure Disease / 1 or less a month ( ) Able to consume solid food

**Personal Care 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 independently or with verbal prompts.

**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, 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.

**Received your final COVID-19 vaccination ( ) Date:** \_\_\_\_\_

**Applicants who utilize adaptive equipment are eligible and should contact the office. 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

**Please explain the reason for any unchecked boxes:**

**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 physical activity ( ) **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:



### 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 ( ) Wheelchair ( ) 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
<b>SWIMMING</b>				
<b>BEACH ACTIVITIES</b>				
<b>HIKING</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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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

Will the Camper require a 1 on 1?  No     Yes - For? \_\_\_\_\_

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**

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:

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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 Campers personal care for the staff to know:

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**Please enclose the Application Deposit of \$250.00.**

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 at 207-934-9655**

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

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

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

**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 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 Camper's 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 to the Ocean Park Beach and Village Center

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 will comply to all COVID-19 camp protocols.

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

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

**OR**

**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**

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 it's Administered	Time(s) & Day(s) Given	Reason(s) for Medication

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

## Oceanwood Medication Policy

All medications MUST be packaged in bubble/blister packs by a pharmacist with the prescriptions attached. These are not single pill packs; all pills must be included in each med administration. This packaging system ensures safe, accurate, and timely administration of your camper's medications.



Regardless if your camper takes 1 (one) or 10 (ten) medications, all regularly scheduled medications, including daily vitamins, must be in bubble packs. Excluded from this list are antibiotics, prednisone, birth control, Coumadin and liquid medications. It is not necessary to send OTC (over the counter) medications to camp as we keep a stock in the medical office for PRN or as needed use only and not for regular daily administration. Daily Vitamins not in bubble packs will not be administered to campers.

Some common medications we stock; Tylenol, ibuprofen, robitussin, tums, loratadine, milk of mag. We do not stock aspirin. **Oceanwood camp will not administer your camper's medications until dinner on the day of check in. You will be responsible to give your camper any medications due before 6:00 pm.** If your camper has had any medication changes since you filled put the application, please fax a current medication list Oceanwood Camp at- 207-934-1586.

You are responsible to arrange the medication packaging for your camper. If your camper resides in a group home or caregiver, you are responsible to ensure they receive this information and have the medications properly packaged. You can check with your current pharmacy to see if they offer this service.



## 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/Diphtheria Booster: _____
Rubella Vaccine: _____
Mumps (DOB after 1956): _____
Measles (DOB after 1956): _____
Date of last TB Mantoux Test: _____
Results: ( ) Positive ( ) Negative
COVID-19: Date of final shot: _____

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: _____
_____
Please list any other activity restrictions: _____
_____

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