HEARTLAND CAMPS

Friendship/Fellowship Camp for the Developmentally Disabled Emergency/Medical

Is your camper: Able to walk (including on slopes) without assistance, non-aggressive, mentally stable, able to interact safely with staff and peers, able to maintain bladder/bowel control? **IF YOUR ANSWER TO ANY PART OF THIS QUESTION IS NO, PLEASE CALL (816)891-1078**

Please make sure your camper comes with all necessary and required appliances needed for their well-being such as:

- ☐ **Hearing Aids (with batteries)**
- ☐ **Batteries (additional)**
- ☐ **Inhalers**
- ☐ **CPAP**
- ☐ **Oxygen**
- ☐ **Other**

Important note for Care Givers please bring a copy of the MARS Sheet to Drop-Off

CAMPER'S NAME _____ Age _____ Gender M_____ F_____

MAILING ADDRESS _____ Birth Date ____/____/_____

CITY _____ STATE _____ ZIP _____

PHONE [1st Contact] _____ PHONE [2nd Contact] _____ PHONE [3rd Contact] _____

Registering home/organization/church _____

Has your camper attended Heartland Camp before? _____

Is your camper physically able to sleep on a top bunk? _____

Behavioral (Attach more pages as needed)

Does the camper get along well with peers? _____ Adults? _____ Is he/she easily excited? _____

Fears or anxieties of which you are aware? _____

How do **you** handle problems or special behavior patterns? (We seek to be consistent with your expectations of the camper.)

Please be specific: _____

What special words or signs will help us communicate with your camper? _____

_____

Physical

SIGHT:	____ Good	____ Fair	____ Poor	____ Glasses
SPEECH:	____ Intelligible	____ Defective	____ Unintelligible	____ Sign Language
HEARING:	____ Good	____ Moderate loss	____ Severe loss	____ Deaf
MOBILITY:	____ Needs assistance	____ Fully ambulatory with no help		
SLEEPING:	____ Good	____ Bad	____ Wets the bed	____ Sleep walks
ACTIVITIES:	____ Hiking	____ Swimming	____ Horse Riding	

Please mark activities with a "Y" for yes or a "N" for no, if your camper can or cannot participate. Please give explanations here:

_____

_____

_____

HEALTH INFORMATION

Please provide complete information. HPC has a registered nurse on duty during programmed camps and this information will allow us to serve you more effectively if injuries or health problems occur. Any information provided will be kept confidential and accessed only by those having a valid reason to know.

Physician and Health Insurance:

Name of physician _____ City _____ Phone ( ) _____

Health/Accident Insurance Co. _____ Policy # _____ Phone ( ) _____

Name of Policy Holder _____

Cause of disability (e.g., Downs or PKU) _____

Date of last physical examination ____/____/____ **(required within 12 months of camp attendance)** If any health conditions change before camp attendance please notify HPC in writing to be attached to this form.

Operations or serious injuries (dates and types) _____

Is camper on a special diet? ____ If yes, please give details _____

In the event of constipation, what should be given? _____

Medication Section doesn't need filled out if MARS is available

Medication Presently Using **	Dosage	Taken when (circle)	Prescribed for (attach if needed)
_____		Breakfast Lunch Dinner Bed	_____
_____		Breakfast Lunch Dinner Bed	_____
_____		Breakfast Lunch Dinner Bed	_____
_____		Breakfast Lunch Dinner Bed	_____

**** Note: All medications must be in the original container with current Rx label.**

Is camper subject to seizures? ____ If yes, please note frequency _____

Date of last seizure ____/____/____ Type and length of seizure _____

Special reactions _____

Special instructions for camp nurse in the event of a seizure _____

Please check any of the following which apply:

Frequent Ear Infections	____	**Current Allergies:**	
Heart Defects/Disease	____	Asthma	____
Convulsions	____	Penicillin	____
Diabetes	____	Hay Fever	____
Bleeding/Clotting Disorders	____	Poison Oak, etc.	____
Hypertension	____	Insect Bites	____
Epilepsy	____	Bee Stings	____
Back Problems*	____	Food*	____
Other*	____	Other*	____

*Please Explain: _____

Immunization Records: Are all immunizations current? ____ Yes ____ No

Please indicate month and year of most recent immunization or booster shot, as best you can:

Tetanus ____/____

Parent/Guardian Statements and Permission:

- **Authorization for Treatment:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, and treatment, and/or to release any records necessary for insurance purposes; and to provide or arrange necessary transportation for my camper. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above.
- **I understand** that health and accident insurance protection are my responsibility.
- **I hereby release** HPC from any liability resulting from misinformation or omission of any information that is necessary in caring for this camper. It is my responsibility to notify the camp of any information changes that occur before this camper arrives.
- **The information provided on this form is correct to the best of my knowledge.**
- ******Unfortunately HPC is not equipped to accommodate all needs. For the protection of campers and staff, and for the integrity of our program, we will deny registration for those who require more professional assistance than HPC is equipped to provide. If you are in doubt, please call to discuss your camper's needs.******

Signature Required _____ Date ____/____/____

Parent/Guardian Signature

Print Parent/Guardian Name_____