**Code Word** (Please assign a code word for your child to serve as identification which will be required at check-out and to receive information regarding your child while at camp.)



**Camp Challenge**

**Camper Application**

P.O. Box 10591 New Orleans, LA 70181

[**www.campchallenge.org**](http://www.campchallenge.org)

**Needs 2 Signatures: Parent/Guardian and Doctor**

**Instructions:** Parent or Guardian must complete the form in its entirety, once complete and has both signatures; the application can be mailed to the camp by the parent. Questions??? Call 504-347-2267

CHILD’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

last first middle

PARENT(S)/GUARDIAN NAME \_

last first middle

ADDRESS:

Street or P.O. Box

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City and State Zip Code Parish

CAMPER’S AGE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENDER : ☐ MALE ☐ FEMALE

T-SHIRT SIZE (circle one) **Youth** S M L **ADULT** S M L XL XXL

**CONTACT INFORMATION**

Parent/Guardian Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone 1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cellular Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1st Emergency Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2nd Emergency Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\* if you do not have a phone, please list a friend, neighbor, or relative so that we can contact you while your child is at camp in the event of a problem or emergency.

***PLEASE ATTACH A COPY OF YOU OR YOUR CHILDS INSURANCE OR MEDICAID CARD!***

(1)

**✰✰✰✰ Must be completed and returned with application ✰✰✰✰**

**Consent Form - Parent or Guardian must Initial each statement before a child can be assigned to camp.**

This form must be completed and returned with your child’s application. Parent or Legal Guardian must read and initial each statement.

**Campers Name**:

\_\_\_\_\_ The Camp may publish my child’s name and address in its weekly camper memory booklet.

* I hereby give consent for said camper to participate in the camping program provided by Camp Challenge, Inc. at the LA Lions Camp Site.
* I will be available by telephone for the first 24 hours that my child is at camp. I have listed the names of at least two people who should be contacted in the event that I cannot be reached during an emergency. I have notified these people that they may be contacted and will make sure that in the event that I am not going to be able to be reached at any point during the camping session that at least one of these two people will be accessible.
* I acknowledge and will recognize the Camp’s right to send home any camper if illness or other reasons deem it necessary including behavioral problems.
* I understand that all campers will receive a health screening before being allowed to check in to camp and that they must be free of contagious conditions ( fever, head lice, etc.) before being admitted.
* I grant permission for the above camper to swim in the Camp’s aquatics program and to ride on the Camp’s canoe boats and paddle boats under direct supervision of the Certified Aquatics Staff in addition to the counselors.
* I hereby grant permission to the Camp’s Director, Nurse, or their authorized representatives to furnish or arrange for the pre-hospital and hospital/ medical care that the camper might require during such time as the camper is a resident at Camp Challenge.

**I am therefore authorizing**:

Physicians, nurses, hospitals and their authorized personnel employed, contracted, or paid on a fee basis by the Camp to perform all treatments and procedures as deemed necessary; and the release of hospital/medical records from the Camp to Physicians, nurses, hospitals and their authorized personnel for the performance of treatments and procedures as deemed necessary.

* The Parents/Guardian and/or their health insurance provider are responsible for all medical bills incurred by above camper that are not covered by the Camp’s group insurance.

***Please include a copy of card with this form!***

**Is the camper covered by family medical/hospital insurance? Yes No**

**Carrier or Plan Name Group Number**

**Name of Insured Social Security # of Policy holder**

* All medications and prescriptions to be administered will be surrendered to the Camp Nurse upon arrival at Camp; dispensing thereof will be derived from the medical statements on the application. Medications will be dispensed according to the prescription written on the bottles or containers.
* I grant permission for photographs and videos to be made of my child by Camp personnel during the camping session for use in Camp publicity which includes brochure, pamphlets, posters, Internet, or other public relations that is in the proper interests of the Camp and is approved by the Camp. The camp is not responsible for photos or videos taken by other campers.
* I acknowledge the Camp’s right to search campers possessions.
* I understand that visitations and phone calls from family/friends are not part of the program and though accepted in emergencies, must be arranged through the Camp’s director.
* The Camp is not responsible for personal items lost, damaged, or misplaced, or stolen.

If needed, please complete: For Religious or other reasons, My child **may not participate** in the following activities:

**Everyone Please Sign:**

Parent / Legal Guardian Signature Date

Please Print Name

(2)

**Parent Checklist**

This form will be copied and given to the counselors caring for your child

Please complete all parts - sorry for some repetition

**Place a check by each item that applies to your child**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_\_ Wt.\_\_\_\_\_\_\_\_ Ht.\_\_\_\_\_\_\_\_

\_\_\_\_**Patient**  \_\_\_\_**Sibling**

**Child’s Diagnosis**

\_\_\_\_Caner Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Sickle Cell

\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last active treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does child have an Individual Education Plan? (IEP)

Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, what is the Primary Exceptionality?

My Child Attends: Regular Education

Special Education

a. Inclusion Class

b. Resource Class

c. Self-Contained Class

**Medications**

\_\_\_\_No Meds \_\_\_\_As Needed Meds

Times for prescribed meds

\_\_\_\_ Breakfast \_\_\_\_ Lunch \_\_\_\_ Dinner

\_\_\_\_Before Bed \_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Seizures** No Yes

Type

Last seizure was

Usual frequency

Usual Duration

Triggered by:

**Allergies** \_\_\_\_None

Food\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insects/plants/other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hearing** \_\_\_\_ Normal \_\_\_\_Hard of Hearing

\_\_\_\_Uses Hearing Aids \_\_\_\_Deaf

**Follows Directions**

\_\_\_\_ Can follow verbal directions

\_\_\_\_Can follow directions with gestures

\_\_\_\_ Needs repeated directions

\_\_\_\_ Can follow a one step direction

\_\_\_\_ Can follow a two step direction

**Ambulation** \_\_\_\_Wheelchair \_\_\_\_Crutches

\_\_\_\_Walks alone w/o devices \_\_\_\_Unsteady

\_\_\_\_Cain/Walker

**Communication**  \_\_\_\_No Problems

\_\_\_\_ Limited but can communicate needs

\_\_\_\_Non-Verbal \_\_\_\_ Sign Language

\_\_\_\_Communication Device

**Social / Behavior**

My Child behaves as a \_\_\_\_ year old.

\_\_\_\_No problems, age appropriate

\_\_\_\_ Problems Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Problems triggered by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Positive Reinforcers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vision**

**\_\_\_\_**Normal \_\_\_\_Limited \_\_\_\_Blind

\_\_\_\_Legally Blind with correction

\_\_\_\_Glasses \_\_\_\_Contacts

(3)

**Place check by each item that applies to your child**

**Self-Help: Toileting**

\_\_\_\_ Attends to own needs \_\_\_\_ Wears Diapers

\_\_\_\_ Wears Pull-Ups

\_\_\_\_ Bring to the bathroom every \_\_\_\_ Hrs.

\_\_\_\_ Needs help with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Cath every \_\_\_\_ Hrs.

\_\_\_\_ Self Cath every \_\_\_\_Hrs. B.M. Every \_\_\_\_HRS.

**Self-Help: Dressing**

\_\_\_\_ Needs no help \_\_\_\_ Needs some help with:

\_\_\_\_ Brushing Teeth \_\_\_\_ Brushing Hair

\_\_\_\_ Zippers \_\_\_\_ Buttons

\_\_\_\_ Snaps \_\_\_\_ Tying Shoes

\_\_\_\_ Needs Total Help

**Self-Help: Bathing**

\_\_\_\_ Needs No Help

\_\_\_\_ Needs some help with\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Bath tub \_\_\_\_ Shower

**Self-Help: Eating / Diet**

\_\_\_\_ Regular Diet \_\_\_\_ Needs No Help

Needs Help With\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Must Be: \_\_Cut \_\_Chopped \_\_Mashed \_\_Pureed

G-Tube\_\_\_\_ NG Tube\_\_\_\_ Tube feed every\_\_\_\_ Hrs.

Favorite Foods:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Diet:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep** \_\_\_\_ No Problems

\_\_\_\_ Regular Bed \_\_\_\_ Top Bunk \_\_\_\_ Lower Bunk

\_\_\_\_ Wets Bed \_\_\_\_ Needs Rails \_\_\_\_ Sleepwalks

\_\_\_\_ Wears diapers at night

**Activities**  \_\_\_\_ Child has PE tube in ears

Swimming: \_\_\_\_ Knows How \_\_\_\_ Special Devices

Any precautions in regards to swimming\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Heat Tolerance**

\_\_\_\_ Good \_\_\_\_ Fair \_\_\_\_ Poor

**Groups** \_\_\_\_ Will stay with group

\_\_\_\_ Wanders off \_\_\_\_ Will run away at times

**Hematology / Oncology Information:** **Check all that apply:**

\_\_\_\_ Central Line \_\_\_\_ Active chemotherapy \_\_\_\_ My child will require blood work at camp

\_\_\_\_ My child will require contact precautions at camp.

Please list any activity restrictions or information that we may need to care for your child on the following page:

**Transportation Information – Check one of the following:**

\_\_\_\_ **Own**: I will provide transportation for my child to and from camp.

\_\_\_\_ **Bus:** I would like for my child to ride the bus to camp. I will transport my child to and from Children’s hospital or the designated bus stop in Baton Rouge.

\_\_\_\_ **Other**: I will need transportation assistance for my child. **Explain**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(4)

**Information**

Has child spent a week away from parent before? \_\_\_\_\_\_ Comments

Has child attended any other camp before? \_\_\_\_\_\_ Where

Has child been to Challenge before? \_\_\_\_\_\_ When

How did you find out about Camp Challenge? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL DIAGNOSIS OR PROBLEMS**: List every physical, mental, and/or medical problem including seizures

1. 4.

2. 5.

3. 6.

**ALLERGIES:** Food: No Yes If yes, list

Medication: No Yes If yes, list

Other: No Yes If yes, list:

**SURGERY**: Type: Date:

Type: Date:

Hospitalized within the last year? Explain:

**MEDICATIONS**

Please provide all information about each medication, follow example below

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication (mg)** | **Amount Given** | **Times Given** | **Special Instructions** |
| **ex:** Phenobarbitol 32mg | 1 tablet | 8 am and 8 pm | takes only with milk |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

\*\*\*\*\*\* Please send all medication in appropriate prescription bottle \*\*\*\*\*\*

**Previous Illnesses (check ones which apply)**

\_\_\_\_ Measles \_\_\_\_ German Measles \_\_\_\_ Chicken Pox \_\_\_\_ Mumps \_\_\_\_ Frequent Ear Infections

**IMMUNIZATIONS (LIST DATES)**

|  |  |  |
| --- | --- | --- |
|  | Year of Basic Immunization | Year of Last Booster |
| DPT |  |  |
| TETANUS |  |  |
| POLIO |  |  |
| MMR |  |  |
| HIB |  |  |
| HEPATITUS B |  |  |

**REMEMBER TO ATTATCH A COPY OF IMMUNIZATIONS WITH APPLICATION!**

(5)

**Physical Exams must be dated after January 1st of the camp year.**

**CAMPER NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Report**

(This part must be completed by a physician & turned in with the application)

**PRIMARY DIAGNOSIS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OTHER DIAGNOSIS STATUS OF EACH DIAGNOSIS**

2.

3.

**Physical Examination**

Height Weight Heart Rate Blood Pressure Respiration Rate

(PLEASE CHECK IF NORMAL OR ABNORMAL)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Normal | Abnormal | Explain if necessary |
| HEENT |  |  |  |
| NECK |  |  |  |
| LUNGS |  |  |  |
| HEART |  |  |  |
| ABDOMEN |  |  |  |
| GENITALS |  |  |  |
| SPINE |  |  |  |
| EXTREMITIES |  |  |  |
| NEURO |  |  |  |
| SKIN |  |  |  |

List chronic or recurring conditions:

Medications: I have reviewed list on page 5 of this form and agree with the medication list

I would like to make the following changes:

Visual acuity Is child legally blind with correction Yes No %Hearing loss

Limitations of Activities:

Other Recommendations

**Licensed Physician’s Signature**

I have examined the above applicant, in my opinion he/she can participate in an active camp program.

Physician’s Signature Date of Exam

Printed Name Phone Fax

Address

Street/box City State Zip

When completed return to:

Camp Challenge

P.O. Box 10591 \* New Orleans, LA 70181

Phone (504) 347-2267

(6)