UPWARD BOUND GATES CAMPUS

CAMPER APPLICATION INFORMATION

P.O. Box C, Stayton OR 97383
Phone (503) 897-2447 Fax (503) 897-4116

OFFICE USE ONLY
Received by:_____
Date received:_____
Payment received: Y N
Receipt No.:_____
Brokerage: Y N
SA Status:_____

This confidential application must be completed in full by all new campers.
Returning campers must complete this every 2 years or by request.
Incomplete applications will be returned and may delay processing for available spots.
Sending in this registration form does not guarantee camper placement.

Average Application completion time: 15 minutes

PLEASE ALLOW A MINIMUM OF 2 WEEKS FOR REGISTRATION PROCESSING.

CAMPER INFORMATION

Please select one: ◯ New Camper ◯ Returning Camper
Registration correspondence should be sent to address of: ◯ Camper ◯ Guardian ◯ Group Home
Camper's Full Name: _____ Birth Date: _____ MM/DD/YYYY
Address: _____ City: _____ State: _____ Zip: _____
County of Residence: _____ Phone: _____ Email: _____
Gender of Camper (check one): ◯ Male ◯ Female
Camper T-Shirt Size (check one): ◯ S ◯ M ◯ L ◯ XL ◯ 2X ◯ 3X
Referral Source: ◯ Web ◯ Friend ◯ Easter Seals ◯ Fair/Expo ◯ DD Services
◯ UBC Event ◯ Other: _____

PARENT/GUARDIAN INFORMATION

Is camper own guardian? ◯ Y ◯ N (If YES skip)

Would you like to subscribe to our e-newsletter?
◯ Yes Please ◯ No Thank you

Guardian
First Name: _____ Last Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Cell #: _____ Work #: _____
Email: _____ Contact Preference: ◯ Phone ◯ Email ◯ US Mail

Joint Guardian
First Name: _____ Last Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Cell #: _____ Work #: _____
Email: _____ Contact Preference: ◯ Phone ◯ Email ◯ US Mail

If parents are divorced, who has custody during camper's time at camp? _____

INSURANCE INFORMATION

Insurance: _____ Policy #: _____ Group #: _____
Medicare #: _____ Medicaid #: _____ SSN #: _____

EMERGENCY CONTACT INFORMATION

In case of emergency, the guardian will be contacted first. Please list 2 different emergency contacts in case the primary contact is not immediately available. These individuals MUST know the applicant AND have permission to pick up applicant at camp if needed.

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

REGISTRATION INFORMATION

PAYMENT INFORMATION

How will you pay for Camp? ◯ Self-Pay ◯ Brokerage ◯ County DDS

Other (specify): _____

Agency Name: _____ Agency Contact: _____

Agency Phone: _____ Agency Email: _____

Agency Fax: _____ Agency Address: _____

_____

Name of person completing this form: _____ Phone #: _____

Length of time you have known the camper?: _____ Number of anticipating sessions attending: _____

Which Gates Camp-Us Program are you registering for?					
☐	Day Camp (Tuesday, Wednesday, Thursday)	☐	Camp-Us Classes (contact Upward Bound Office for current offerings)	☐	Harvest
☐	Respite Care	☐	Holiday Camp (contact Upward Bound office for specific dates)	☐	Thanksgiving
☐	Transition Program	☐	Easter	☐	Christmas

Camper's favorite activity at home: _____

Favorite activity away from home: _____

Other camps camper has or will attend: _____

How do you know the camper wants to attend UBC? _____

We want you to see your friends at UBC. Is there someone you would prefer to be schedule to attend the same time with?

Are there any obstacles to scheduling we should be aware of (i.e. personal conflicts w/ other attendees, home sickness, fears, etc.)?

General Comments/Expectations/Questions/Concerns with regards to Camp Activities:

DIAGNOSIS INFORMATION (LABELS) (PLEASE SELECT ALL THAT APPLY)

PRIMARY DIAGNOSIS: _____

VISUAL CHALLENGES: ◯ NONE ◯ BLIND ◯ SOME SIGHT ◯ GLASSES

HEARING CHALLENGES: ◯ NONE ◯ DEAF ◯ SOME HEARING ◯ HEARING AIDES

OTHER CHALLENGES: (PLEASE EXPLAIN)

SEIZEURES: ◯ NONE ◯ GRAND MAL ◯ PETIT MAL ◯ OTHER: _____

VNS (VAGUS NERVE STIMULATION): ◯ Y ◯ N

FREQUENCY: _____ DURATION: _____ DATE OF LAST SEIZURE: _____

MOBILITY NEEDS

WALKING: ◯ INDEPENDENT ◯ MINIMAL ASSISTANCE ◯ COMPLETE ASSISTANCE

USES MOBILITY AIDES: ◯ Y ◯ N PLEASE LIST: _____

USES WHEELCHAIR: ◯ Y ◯ N WHEELCHAIR TYPE: ◯ POWER ◯ MANUAL

MOBILITY IN WHEELCHAIR: ◯ INDEPENDENT ◯ MINIMAL ASSISTANCE ◯ COMPLETE ASSISTANCE

WHEELCHAIR TRANSFERS: ◯ INDEPENDENT ◯ MINIMAL ASSISTANCE ◯ COMPLETE ASSISTANCE

WHEELCHAIR TRANSFER METHOD: ◯ STAND/PIVOT ◯ NON-WEIGHT BEARING (2 PERSON LIFT) ◯ HOYER

SUGGESTIONS/COMMENTS/ADDITIONAL INFORMATION:

PERSONAL CARE NEEDS

DRESSING: ◯ INDEPENDENT ◯ MINIMAL ASSISTANCE ◯ COMPLETE ASSISTANCE

BRUSHING TEETH/DENTURE CARE: ◯ INDEPENDENT ◯ MINIMAL ASSISTANCE ◯ COMPLETE ASSISTANCE

WASHING HANDS/FACE: ◯ INDEPENDENT ◯ MINIMAL ASSISTANCE ◯ COMPLETE ASSISTANCE

SHAVING: ◯ INDEPENDENT ◯ MINIMAL ASSISTANCE ◯ COMPLETE ASSISTANCE

SHOWERING: ◯ INDEPENDENT ◯ MINIMAL ASSISTANCE ◯ COMPLETE ASSISTANCE

TOILETING: ◯ INDEPENDENT ◯ MINIMAL ASSISTANCE ◯ COMPLETE ASSISTANCE

FEMALE MENSTRUAL NEEDS: ◯ INDEPENDENT ◯ MINIMAL ASSISTANCE ◯ COMPLETE ASSISTANCE

CONTINENCE: ◯ ALWAYS ◯ SOMETIMES ◯ INCONTINENT ◯ INCONTINENT AT NIGHT

TOILETING AIDES: ◯ ATTENDS ◯ CATHETER – TYPE: _____ ◯ URINAL

◯ OTHER: _____

TOBACCO USE: ◯ NONE ◯ CHEWS ◯ SMOKES TOBACCO PRODUCTS

DESCRIBE ASSISTANCE/MONITORING NEEDS WITH TOBACCO USE:

SUGGESTIONS/COMMENTS/ADDITIONAL INFORMATION:

SLEEPING NEEDS

SLEEPS ALL THROUGH NIGHT? ◯ Y ◯ N

USUALLY WAKES UP BEFORE 7AM? ◯ Y ◯ N

USUALLY TAKES A MID-DAY NAP? ◯ Y ◯ N

AWAKEN AT NIGHT FOR RESTROOM? ◯ Y ◯ N

HOW MANY TIMES: ◯ 1-2X ◯ >3X

WILL SLEEP IN ROOM WITH OTHERS? ◯ Y ◯ N

USUALLY GOES TO SLEEP AFTER 9PM? ◯ Y ◯ N

USES A CPAP MACHINE? ◯ Y ◯ N

NEEDS TO BE TURNED AT NIGHT? ◯ Y ◯ N

HOW MANY TIMES: ◯ 1-2X ◯ 3-4X ◯ >4X

SUGGESTIONS/COMMENTS/ADDITIONAL INFORMATION:

MEAL TIME NEEDS

CUTTING FOOD: ◯ INDEPENDENT ◯ MINIMAL ASSISTANCE ◯ COMPLETE ASSISTANCE

FOOD TO MOUTH: ◯ INDEPENDENT ◯ MINIMAL ASSISTANCE ◯ COMPLETE ASSISTANCE

DRINKING FROM CUP: ◯ INDEPENDENT ◯ MINIMAL ASSISTANCE ◯ COMPLETE ASSISTANCE

SPECIAL PREPARATIONS: ☐ PUREED FOOD ☐ CHOPPED FOOD ☐ THICKENED LIQUIDS ☐ LOW SALT ☐ LOW SUGAR ☐ #CALORIES- _____

DIABETIC: ◯ Y ◯ N YES – DIET CONTROLLED: Y ◯ N ◯ INSULIN CONTROLLED Y ◯ N ◯

TESTING TIMES: _____ AVERAGE BLOOD GLUCOSE: _____

SPECIAL UTENSILS: ◯ Y ◯ N DYSPHASIA Y ◯ N ◯

KETOGENIC: ◯ Y ◯ N GLUTEN-FREE: Y ◯ N ◯ LACTOSE INTOLERANT: Y ◯ N ◯

CHEWING DISORDER/MISSING TEETH: Y ◯ N ◯ PRADER/PICA: Y ◯ N ◯

PROBLEM FOODS/FOOD RESTRICTIONS/SPECIAL DIET INFO – (IF APPLICABLE PLEASE EXPLAIN)

OTHER MEAL TIME NEEDS:

ALLERGY INFORMATION

PLEASE LIST & EXPLAIN ALL KNOWN FOOD ALLERGIES:

REACTIONS:

PLEASE LIST & EXPLAIN ALL KNOWN NON-FOOD ALLERGIES:

REACTIONS:

MEDICATIONS NEEDS:

PRESCRIBED MEDS: Y ◯ N ◯ MEDICATION BEFORE 6AM OR AFTER 10 PM? Y ◯ N ◯

MEDS 1-2X DAILY: Y ◯ N ◯ MEDS 3-4X DAILY: ◯ Y N ◯ MEDS >4X DAILY: Y ◯ N ◯

NEBULIZER: Y ◯ N ◯ FREQUENCY: _____

SPECIAL PROTOCOLS Y ◯ N ◯ (IF YES – PLEASE EXPLAIN)

COMMUNICATION NEEDS:

ABLE TO CLEARLY COMMUNICATES WANTS/NEEDS? Y ◯ N ◯ ABLE TO FOLLOW 1 OR 2 PART DIRECTIONS? Y ◯ N ◯

ABLE TO READ? Y ◯ N ◯ ABLE TO WRITE? Y ◯ N ◯

USES SIGN LANGUAGE/ASL? Y ◯ N ◯ ABLE TO TALK? Y ◯ N ◯

USES GESTURES TO COMMUNICATE? Y ◯ N ◯ USES COMMUNICATION SYSTEM? Y ◯ N ◯

SUGGESTIONS/COMMENTS/ADDITIONAL INFORMATION:

PERSONALITY/BEHAVIORAL/SUPERVISION NEEDS:

DOES CAMPER REQUIRE 1:1 TOTAL CARE OR SUPERVISION? Y N (IF YES – PLEASE EXPLAIN)

FEARS: ☐ WATER ☐ ANIMALS ☐ FALLING ☐ HEIGHT ☐ DARK ☐ PEOPLE/CROWDS

☐ OTHER: _____

PERSONALITY ☐ HAPPY-GO LUCKY ☐ HELPFUL ☐ WANDERS ☐ CAUTIOUS ☐ WITHDRAWN/SHY

☐ YELLS/SCREAMS ☐ INTERACTS WELL W/OTHERS ☐ PARTICIPATES IN A GROUP ENVIRONMENT

BEHAVIORS THAT ARE INJURIOUS TO SELF/OTHERS? Y N (IF YES – PLEASE EXPLAIN)

☐ PHYSICALLY AGGRESSIVE – PLEASE EXPLAIN: _____

☐ SELF ABUSIVE – PLEASE EXPLAIN: _____

☐ ATTENTION SEEKING – PLEASE EXPLAIN: _____

WHEN DO THESE BEHAVIORS OCCUR? IS THERE A COMMON TRIGGER FOR THESE BEHAVIORS? PLEASE EXPLAIN.

DOES THE CAMPER REQUIRE PHYSICAL MANAGEMENT? PLEASE EXPLAIN.

DO YOU HAVE ANY SPECIFIC SUGGESTIONS OR REDIRECTION TECHNIQUES THAT MIGHT BE HELPFUL IN SERVING ANY BEHAVIORAL NEEDS?

SUGGESTIONS/COMMENTS/ADDITIONAL INFORMATION:

In compliance with current Upward Bound Camper Enrollment Criteria, Campers who are abusive to self, others, or properties may not be considered appropriate for acceptance into overnight programs. Campers with a history of physically or sexually aggressive behavior or who exhibit such behaviors while in attendance may be dismissed from the program immediately.

NOTE: At director's discretion, a private personal attendant may be required to accompany and manage the behavior or personal care of any camper whose needs exceed the limits of our eligibility policy.

PUBLIC INFORMATION

In consideration of participation in Upward Bound Camp activities, I hereby consent to the use of any film/videotape/sound recording made of _____ (Camper's Name), by Evans Creek Retreat/Upward Bound Camp and irrevocably assign all rights in the same to Evans Creek Retreat/Upward Bound Camp, and those acting with its permission, for the purpose of illustration, publication, or broadcast in connection with the work, advertising, and promotion of Evans Creek Retreat/Upward Bound Camp. I have read the foregoing release and authorization before affixing my signature and warrant that I fully understand the contents thereof.

Signature of Parent, Legal Guardian, or Independent Adult Camper Date

ACKNOWLEDGEMENT

I have read and understood this application. It is correct to the best of my knowledge, and the applicant described herein has permission to engage in all programs activities except as noted. I understand that omitting or falsifying information may compromise planning for the success of this camper and may lead to disqualifying the camper from attendance. In further consideration for acceptance, I hereby release and waive any claim, cause, or action which may accrue against Evans Creek Retreat/Upward Bound Camp arising from participation in any camp activity approved by any of said persons.

Signature of Parent, Legal Guardian, or Independent Adult Camper Date

PHYSICALS AND MARS

A copy of current medication list or medication administration record will be necessary before participation. Upward Bound continues to provide programs accredited by the American Camping Association, a national organization that defines the standards for quality camp experiences. To meet accreditation standards it is necessary for UBC to have on file at camp a copy of the most recent camper physical. The American Camping Association standard REQUIRES a physical within six months of the camp date.

UBC does understand the financial challenges this may present for some campers. However, current health information is an essential ingredient in providing a quality camp experience. Please contact the office if for some reason this camper is not financially able to submit a physical current within the last year.

The physical does not need to be on the UBC form however, it must be signed by a licensed physician approving health appropriate for camp attendance. It is important that the physician list any and all restrictions and health precautions, and current medications and treatments to be administered at camp. In the event of camper's chronic negative health history, the health care personnel of UBC reserves the right to request additional information from the camper health care provider including a physical before attending camp.

Camper/Guardian Signature: _____ Date: _____

Camper/Guardian Printed Name: _____

Witness - Signature: _____ Date: _____

Witness – Printed Name: _____