

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)

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SEIZURES: 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:

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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:

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SUGGESTIONS/COMMENTS/ADDITIONAL INFORMATION:

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SLEEPING NEEDS

SLEEPS ALL THROUGH NIGHT?	Y	N	WILL SLEEP IN ROOM WITH OTHERS?	Y	N
USUALLY WAKES UP BEFORE 7AM?	Y	N	USUALLY GOES TO SLEEP AFTER 9PM?	Y	N
USUALLY TAKES A MID-DAY NAP?	Y	N	USES A CPAP MACHINE?	Y	N
AWAKEN AT NIGHT FOR RESTROOM?	Y	N	NEEDS TO BE TURNED AT NIGHT?	Y	N
HOW MANY TIMES:	1-2X	>3X	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: _____