



2012 Camp Application Checklist / Camper Paperwork
(for campers registering online)

****Return this checklist with Paperwork****

Name of Camper: _____

1. I have read the **Camp Application Guide** _____ (Keep for your records)
(attached separately)

2. I have completed the online application questions _____ (Please be thorough)

3. Acceptance Criteria and Agreement _____ (Reviewed and signed)

4. Health History Form _____ (Completed and signed)

5. Camp Standing Orders _____ (Completed and signed)

6. Examination Form _____ (Attached w/Dr.'s Signature)

Must be dated within **12months** of attending
Due by June 1st at the latest

or

_____ (Will send at a later date)

or

_____ (Current copy on file at camp)

7. Recent **Photograph** of Camper (for nurses/ID) _____ (Attached to application)

(can be a black and white copy but must be clear)

or

_____ (Emailed picture to Kathy)

Kathy@mhkc.org

****The application is complete if all areas are checked****

If a camper has any support plans such as a Behavior Plan, Therapeutic Dining Plan, etc please attach those documents.

I verify that the enclosed application contains all information required on this checklist (examination form can be sent in at a later date if needed).

Signature: _____ Date: _____

Person Completing Form

ACCEPTANCE CRITERIA AND AGREEMENT
(Please read and sign this page)

Camper's Name: _____

Mt. Hood Kiwanis Camp, Inc. accepts applicants regardless of race, color, national origin, sex, sexual orientation, veteran status or disability. The following criteria are used to determine acceptance: **The applicant (1) must be able to benefit from the camp program, (2) must be adaptable to the group living environment, (3) must not be physically, verbally, or sexually abusive, (4) must have no history of arson or fire setting AND (5) must be free of conditions and behaviors that might not be manageable in a camp setting.** (See Program Eligibility Standards)

We (camper and parent/guardian) wish the applicant who signs below to participate in the Mt. Hood Kiwanis Camp program. We recognize that there may be risk of injury during such participation and that certain dangers and accidents may occur. We further agree that each person participating in the program must follow safety instructions, remain in areas designated by staff, and refrain from behavior that is harmful to himself/herself or others. Failure to do so will be cause for the camper's dismissal from the program. Please be aware that all of Mt. Hood Kiwanis Camp's employees and volunteers are mandatory abuse reporters. Any allegations or reasonable cause to suspect abuse or neglect will be reported directly to the Department of Human Services.

In consideration of participation in the program, the camper and the camper's parents hereby release and discharge the Mt. Hood Kiwanis Camp, Inc., its officers, agents and employees; Kiwanis Clubs and their members; Portland State University, its employees and students; the State of Oregon; the U.S. Forest Service and the agents and insurers of each of them, from any and all claims, arising from negligence including but not to exceed ordinary negligence as allowed by Oregon state law, or breach of contract, because of any injury to the applicant during participation in the program. Further, we agree to defend and indemnify the Camp, its officers, agents and employees; Kiwanis Clubs and their members; Portland State University, its employees and students; the State of Oregon; the U.S. Forest Service and the agents and insurers of each of them, from actions for damages or expense caused to other participants in the program which are caused by our camper.

I give permission for the Camp Director or his/her designee to search camper's belongings, with camper present, when the health, well-being or safety of the camper or others requires a search.

I give permission for camper to be transported in camp-designated vehicles for off-site trips and for emergency or routine medical care.

I understand that the Mt. Hood Kiwanis Camp must provide a safe and cooperative group experience for all campers and that the applicant may be dismissed from the program for reasons including behavior, illness, injury or homesickness.

I understand that any refund for a camper leaving the camp early will be prorated based on the number of hours spent at camp.

I have read and understand the fee structure, refund and balance-due policies and agree to pay as stated.

I understand that photographs may be taken at the camp showing the campers and camp staff in their usual camp activities. Some photographs will be used by Mt. Hood Kiwanis Camp and Portland State University for both promotional and educational purposes in printed materials, on our website and in other media. I also understand that other parents, guests, staff, and volunteers will be taking pictures as well and it is out of Mt. Hood Kiwanis Camp's control to monitor the use of these pictures.

Yes, I agree that Mt. Hood Kiwanis Camp, Inc. and Portland State University may take photographs of campers in usual camp activities and that the pictures may be used for the above purposes as deemed proper by Mt. Hood Kiwanis Camp, Inc. and/or Portland State University.

Initial here if you give permission: _____

No. I do not give permission for Mt. Hood Kiwanis Camp, Inc. and Portland State University to use photographs of the camper for promotional or educational purposes.

Initial here if you do NOT give permission: _____

I DO HEREBY ACKNOWLEDGE that I have carefully read all of the foregoing information and I understand and agree to its contents.

X _____
Signature of Parent or Guardian **Date**

I understand and agree to follow the policies of the Mt. Hood Kiwanis Camp and any restrictions placed on my camp activities.

X _____
Signature of Camper **Date**

Mt. Hood Kiwanis Camp Health History

Please note: Some questions on this form may duplicate the actual application. This is due to documentation requirements and our review process. We apologize for any inconvenience.

Camper's Name: _____ **Date of Birth:** _____

Parent/Guardian name: _____ **Relationship:** _____

Home Phone : (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

1. Emergency contact other than above: _____ **Relationship:** _____

Home Phone : (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Health Insurance:

1. Is the camper covered by medical/hospital insurance? [] Yes [] No

If yes, give carrier or plan name _____ Policy/Group # _____

Name of insured/relationship to camper _____ Insurance ID # _____

2. Is the camper covered under Medicaid? [] Yes [] No

If yes, please provide numbers: Medicaid: _____

3. Other coverage: _____

Physician Information:

1. Camper's Primary Care Physician: _____ Phone #: _____

Physician Address: _____ City: _____ State: _____ Zip code: _____

2. Additional Physician: _____ Phone #: _____

Physician Address: _____ City: _____ State: _____ Zip code: _____

Allergies: List all known allergies. **Describe reaction and management of the reaction.**

1. Medication allergies: _____

2. Food Allergies: _____

3. Other allergies (include insect stings, hay fever, asthma, animal dander, etc.): _____

Seizures: Does the camper have a history of Seizures? [] Yes [] No (attach additional information if needed)

If yes, please explain (date of last seizure, frequency/duration, characteristics, medication): _____

Bowel Movements: Does the camper have daily bowel movements? yes no

Additional comments: _____

Limitations: Describe any limitation or restriction of camp activities (activities may include: swimming, hiking, horseback riding, adventure ropes course, canoeing, and white water rafting). If none, please write no limitations: _____

Medication Administration: How does the camper take medication?

Crushed Whole Liquids Applesauce Pudding Other (please explain)

Other Medical Conditions/Concerns/Instructions (Asthma, Diabetes, G-Tube, PICA, etc): _____

Health History Continued: Medications

Although we realize that the camper's meds may change before camp, this list will allow the camp nurses to be more informed of the campers medical needs. Please include over-the-counter or non-prescription drugs taken routinely.

[] This person takes **NO** medications on a routine basis.

Very important: please see the Application Guide for details regarding packing medication and having proper doctors' orders. **Medication must be in original containers with current labels.**

Name of Prescription	Dosage	Time Given

Name of PRN (as needed)	Dosage	Reason for Medication

Name of Vitamin/Supplement	Dosage	Time

OVER THE COUNTER MEDICATION ADMINISTRATION

In addition to the medications you provide for your camper, camp nurses have standing orders to administer certain over-the-counter-medications. These medications are listed in Section VI for you to review and sign off on.

Important: Please indicate how you would like to be notified if your camper requires over the counter medication while at camp:

____ (initials) Document that the medication was given on the communication log.

** If the camper is seriously ill or the over the counter medication does not relieve the symptoms you will be contacted**

or

____ (initials) Call me before the medication is given. Please note that this option may cause a delay in your camper's symptoms if you are not readily available.

Health History - Continued

Have/has the camper:	Yes	No		Yes	No
1 Recent injury, illness or infectious disease?	[]	[]	12 Ever had seizures?	[]	[]
2 Have a chronic or recurring illness?	[]	[]	13 Been diagnosed with a heart murmur?	[]	[]
3 Ever been hospitalized?	[]	[]	14 Ever had high blood pressure?	[]	[]
4 Ever had surgery?	[]	[]	15 Ever had back problems?	[]	[]
5 Have frequent headaches?	[]	[]	16 Ever had problems with joints?	[]	[]
6 Had a head injury?	[]	[]	17 Have any skin problems?	[]	[]
7 Ever been knocked unconscious?	[]	[]	18 Have diabetes?	[]	[]
8 Ever had frequent ear infections?	[]	[]	19 Have asthma?	[]	[]
9 Ever passed out during or after exercise?	[]	[]	20 Had mononucleosis in the past year?	[]	[]
10 Ever been dizzy during or after exercise?	[]	[]	21 If female, abnormal menstrual history?	[]	[]
11 Ever had chest pain during/ after exercise?	[]	[]	22 Ever had an eating disorder?	[]	[]
			23 Required psychiatric treatment?	[]	[]

Please explain any 'yes' answers, noting the number of the questions: _____

Immunizations: Note: If the camper does not have up to date immunizations due to religious beliefs or other reasons, please request a waiver form from the camp office.

Are all immunizations that would be required for school currently up to date? yes no

What was the date of the camper's last tetanus shot? Month Year

<p>Which of the following has the participant had?</p> <ul style="list-style-type: none"> <input type="radio"/> Measles <input type="radio"/> Chicken pox <input type="radio"/> German measles <input type="radio"/> Mumps <input type="radio"/> Hepatitis <input type="radio"/> _____ Date of last TB <input type="radio"/> _____ Mantoux test Result 	<p>Please give dates of last immunization for:</p> <p><i>Month/Year</i></p> <p>_____ DTP (Diphtheria, Tetanus, Pertussis)</p> <p>_____ MMR (Mumps, Measles, Rubella)</p> <p>_____ IPV/OPV (Polio)</p> <p>_____ Hepatitis B</p> <p>_____ Varicella (Chicken Pox)</p> <p>_____ Haemophilus influenzae B</p>
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(Attach additional pages if necessary)

This Box Must be Complete for Attendance

Parent/Guardian Authorizations: This health history information is correct and complete to the best of my knowledge. The person herein described has permission to engage in all camp activities except as noted above. I hereby give permission to the camp to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any record necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for this participant. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the participant. I also agree to be responsible for any expenses which may be incurred in providing emergency medical or surgical treatment to this participant. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper: _____

Printed Name _____ **Date:** _____

Camp Physician Standing Orders

Camper's Name: _____

At times, it may become necessary to treat minor ailments from our Camp Physician Standing orders. The following medications may be used. Please indicate whether these medications are acceptable to give your camper under the direction of the Mt. Hood Kiwanis Camp Standing Orders.

MEDICATION	YES	NO
Benadryl or Generic Equivalent (for allergic reactions)		
Aloe Vera Gel		
Antibiotic Ointment (e.g. Neosporin)		
Calamine Lotion/Caladryl		
Cough Syrup		
NyQuil (over 12 years old only)		
DayQuil (over 12 years old only)		
Cough Drops		
Dulcolax tabs (for constipation)		
Glycerin or Dulcolax suppository (for constipation)		
Epinephrine (for serious allergic reaction)		
Fleet Enema		
Head Lice Shampoo		
Hydrocortisone Cream 1%		
Advil/Ibuprofen		
Tylenol or Generic Equivalent		
Ematrol or Generic Equivalent (for nausea)		
Sarna Lotion		
Motrin or Generic Equivalent		
Midol or Generic Equivalent (for menstrual cramps)		
Ivy Dry/Ivy Stat or Generic Equivalent (for poison oak)		
Kaopectate		
Milk of Magnesia		
Pepto Bismo (for upset stomach, nausea, or diarrhea)		
Rash Ointments (e.g. Destin)		
Solarcaine		
Saline-for eyes		
Swimmer's Ear or Generic Equivalent- water drying drops		
Sunblock		
Auralgen ear drops (earache)		
Bug Spray		
Aspirin		
Tums		

I authorize the Mt. Hood Kiwanis Camp to administer the medications listed on the Camper Medication Record page according to the manufacturers' written instructions. The medication information given today supersedes any previous information given at the time of registration.

I authorize the Mt. Hood Kiwanis Camp to administer any of the above medications indicated "yes" according to the Camp Standing Orders, as necessary for minor ailments.

Parent/Guardian/Camper Signature: _____ **Date:** _____

Camper Physical: To Be Completed by Licensed Health Care Provider

Campers Name: _____ Date of Birth: _____ **Date examined:** _____

The above-named camp participant must have an exam within 12 months prior to camp attendance.

Height: _____ Weight: _____ Blood Pressure: _____

Diagnoses: _____

The participant is under the care of a physician for the following conditions:

Recommendations and Restrictions while at Mt. Hood Kiwanis Camp

Treatment to be continued at camp: _____

Medications to be administered at camp including name, dosage, frequency (you can attach a list as well):

Any medically prescribed dietary restrictions: _____

Known allergies: _____

In my opinion, the above applicant [] is [] is not able to participate in an active camp program.

Describe any limitation or restriction on camp activities (activities may include: swimming, hiking, horseback riding, adventure ropes course, canoeing, and white water rafting). If no restrictions, write none: _____

Does this person have a positive diagnostic x-ray for Atlantoaxial Dislocation Condition? ____ If yes, give activity restrictions relating to horseback riding, adventure course, etc. _____

Please attach additional information that may assist health care staff at camp.

Signature of Health Care Provider _____ Date: _____

Printed Name _____ Phone: _____

Office Address _____

**Please send to Mt. Hood Kiwanis Camp Office, attention Kathy Werschkul
10725 SW Barbur Blvd. Suite 50, Portland OR 97219-5430**