

# Jesus Cares Camp Phillip – 2017

JESUS CARES MINISTRIES  
A MINISTRY OF THE LUTHERAN  
HOME ASSOCIATION



***Whoohooooo!!!! We are so glad you are interested in coming to Camp Phillip for Jesus Cares Camp! Here are a few things you need to know:***

## **Are you eligible for camp?**

Jesus Cares week at Camp Phillip is staffed with volunteers and designed for persons with mild to moderate developmental disability, who are *ambulatory*. There is significant walking at camp to and from cabins. Please consider that camp activities require some strength and stamina. *Both the cabins and the main dining hall do NOT have air conditioning.* Campers need to participate in activities as planned. Campers must have independent toileting and feeding skills and be able to walk independently. Our camp counselors are primarily young adults who may not be experienced in giving personal care such as when a camper has a toileting accident on a regular basis.

## **When is camp?**

July 3-7, 2017. Check-in will be at 2:30pm. Please do not plan to arrive earlier than that. On departure Friday, come around 10:30am for a short service and awards ceremony with checkout to follow.

## **Where is camp?**

W9944 Buttercup Avenue in Wautoma, WI. The phone number for Camp Phillip is (920) 787-3202. You are responsible for transportation to and from camp.

## **Cost**

The fee for this year will be **\$452**. Everyone is responsible for a **\$100.00** deposit fee (payable to Camp Phillip) due with your camper forms by **May 1st**. The balance of the fee (\$352) is to be sent to the address below at least 7 days before camp--June 26th. **Please make sure all pages of the forms are filled out completely, signed, and the deposit included.**

## **Send to:**

**Camp Phillip  
W9944 Buttercup Avenue  
Wautoma, WI 54982.**

# \*\*\*\*NEW Medication requirements\*\*\*\*

Medications will ONLY be accepted in **pharmacy prepared blister/bubble** packs for safety and ease of administration. The images below are the most commonly seen types of blister packs in our area. These will all be accepted at camp. If your pharmacy carries a different style, please let us know and one of our nurses will contact you.



- **What is NOT acceptable?** Nurses will NOT accept home fill baggies or envelopes or pill minders. Bottles will be accepted for as needed medications only and must include instructions for use from doctor.



- **Liquids and powders:** Can be sent in original containers with current administration instructions on pharmacy label
- **As needed medications:** These medications will be accepted either in bubble packages or ORIGINAL pill bottles with current administration instructions. Expiration date must be current. *Please note that as needed medications can only be given with permission!* We do carry some products. See the over the counter section of the application.
- **Pudding/Applesauce:** Is NOT provided. Please send if this is required for medication administration.
- **Medication Lists:** Please provide printed list from provider at time of application. We realize this may change by camp, but having a general idea early will help us plan.
- **Note:** All medications will be collected and administered by nursing staff for the safety of the other campers.
- **What if I'm not sure or bubble packs are hard to get in our area?** Maybe one of our nurses can help! Check the appropriate box on the camp form (under MEDICAL CARE ) and one of our nurses will be in touch!

Please make a copy of your camper's insurance card (such as Forward Health) or if they have a T-19 card provide that. Not all campers will have a T-19 card.

It is important that we get new camper forms each year. Their needs may have changed. Having complete and current forms is of great help to our staff to allow us to properly serve our guests and assure they have a great time at camp. Please complete and return the camper information packet as soon as possible!

# CAMPER REGISTRATION PACKET

## Jesus Cares Camp Phillip 2017

Camper name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_ Nickname: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Age: \_\_\_\_\_ Date of birth: \_\_/\_\_/\_\_\_\_ Gender (circle): Male Female

**T-shirt size** (please circle size): **Small Medium Large XL XXL 3XL**

Is the patient their own guardian? Yes No

Camper lives (circle): Independently With family With foster family Group home Residential facility

First time camper: No Yes If yes, who referred you to camp? \_\_\_\_\_

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**Name of residential facility or agency** (If applicable) \_\_\_\_\_

**Agency contact:** \_\_\_\_\_ Office (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

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**Parent/Guardian** \_\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Where should program correspondence be sent? Self (Camper) Guardian Agency listed above

Should program correspondence be sent via: Mail Email

**Additional emergency contacts:**

1. Name: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_  
Day phone: (\_\_\_\_) \_\_\_\_\_ Evening phone: (\_\_\_\_) \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_  
Day phone: (\_\_\_\_) \_\_\_\_\_ Evening phone: (\_\_\_\_) \_\_\_\_\_

For emergency purposes, ALL Campers MUST complete this section.

Medical assistance number: \_\_\_\_\_

Insurance carrier: \_\_\_\_\_ Policy number: \_\_\_\_\_

Primary medical doctor \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

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**MEDICAL CARE:**

I have a medical concern regarding camp and wish to be contacted by one of the nurses.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Primary diagnosis: \_\_\_\_\_

Secondary diagnosis: \_\_\_\_\_

Cognitive ability/developmental delay: Mild Moderate Severe developmental delay

**Allergies:** None Food Drug Environmental Other

List & describe reaction: \_\_\_\_\_

**Seizure disorders:**

No seizures Seizures, Description: \_\_\_\_\_  
Seizure frequency: \_\_\_\_\_ Date of last seizure: \_\_\_\_\_  
At what point do we call EMS for seizure related activity? \_\_\_\_\_  
Does someone need to be contacted if camper has a seizure? \_\_\_\_\_

**Diabetes:** Is the camper diabetic? Yes No Normal blood sugar range: \_\_\_\_\_  
How frequently must blood sugars be checked at camp? \_\_\_\_\_

**Other health history:**

- |   |  |
|---|--|
| <input type="checkbox"/> ADD/ADHD                     | <input type="checkbox"/> Joint problems        |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Psychiatric treatment |
| <input type="checkbox"/> Chronic or recurring illness | <input type="checkbox"/> Recent surgery        |
| <input type="checkbox"/> CHF                          | <input type="checkbox"/> Skin disorder         |
| <input type="checkbox"/> COPD                         | <input type="checkbox"/> Stomach problems      |

- Constipation
- Shortness of breath
- Bleeding/clotting disorders
- Heart problems (heart failure, abnormal rhythm, blood pressure)
- Heat related problems (Camp has no air conditioning.)
- High blood pressure

**Other:**

- Uses a CPAP or BIPAP?
- Smoke? Type? Is there a schedule? Who manages?
- Wears glasses
- Wears dentures

**Explain:** \_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS:**

Does the camper take medications? Yes No

**All medications must now be bubblepacked** as indicated on the attached flier:

- I understand the new medication bubble pack guidelines and will have no trouble complying.
- I am confused by the new bubble pack guidelines and wish to be contacted by the nurse.
- It will be difficult for me to obtain bubble packs and wish to be contacted by the nurse.

***Please attach copy of current med list. We realize it may change, but this aids preparations!***

Do meds need to be crushed? No Yes Applesauce/pudding? No Yes (please send)

**Permission to use over the counter (OTC) medication:**

- |  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tylenol                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Cough syrup         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Antibiotic ointment |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ibuprofen               | <input type="checkbox"/> Yes <input type="checkbox"/> No Stool softener      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Benadryl                | <input type="checkbox"/> Yes <input type="checkbox"/> No TUMS/Roloids        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hydrocortisone ointment | <input type="checkbox"/> Yes <input type="checkbox"/> No Pepto-Bismol        |

Permission is given to use these additional OTC drugs: \_\_\_\_\_

***Please provide administration instructions below if different from OTC label instructions.***

If the camper frequently experiences any of the following, please check the box and describe how these are best treated.

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Nausea       | <input type="checkbox"/> Nightmares    |
| <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Dizziness    | <input type="checkbox"/> Headaches     |
| <input type="checkbox"/> Over fatigue | <input type="checkbox"/> Homesickness  |
| <input type="checkbox"/> Earaches     | <input type="checkbox"/> Constipation  |

Any additional information: \_\_\_\_\_  
\_\_\_\_\_

**RELIGIOUS BACKGROUND:**

Church affiliation: WELS  ELS Other: \_\_\_\_\_  
Name of church: \_\_\_\_\_ Pastor's name: \_\_\_\_\_  
Is camper baptized: Yes No Is camper confirmed: Yes No  
Does camper attend church services regularly? Yes No  
Does/has camper attend religious instruction class? Yes No  
If yes, please describe type (Sunday school, Confirmation class, Bible study, etc.)  
\_\_\_\_\_

**MOBILITY:**

Can the camper walk: Unaided With physical assistance Walker/cane  
Uses braces or AFOs: No Yes (circle): Right Left Both  
Walking speed: Slow Medium Fast  
Wheelchair needed for long distances? No Yes--Please bring. Camp does not have paved walkways; use is difficult.  
Any additional information: \_\_\_\_\_

**SPEECH & COMMUNICATION:**

Verbal Non-verbal Able to read? Yes No Able to write? Yes No  
If speech is severely limited, how does the camper communicate? \_\_\_\_\_  
Commonly used signs/gestures: \_\_\_\_\_

**PERSONAL HYGIENE:**

Showers independently Needs verbal cues Needs total assistance showering  
Needs assistance with: Shampooing hair Washing body Adjusting water temp Brushing teeth  
Comments: \_\_\_\_\_

**DRESSING:**

Dresses/undresses independently Needs partial assistance Needs total assistance  
Can put on: Underwear Socks Shirt Pants Can: Button Snap Zip Tie shoes  
Comments: \_\_\_\_\_

**SLEEP PATTERNS:**

Sleeps through night: Yes No, explain \_\_\_\_\_  
Can the camper climb a ladder and sleep on a top bunk (with rail)? Yes No

**BATHROOM USE:**

Uses toilet independently Needs reminders Needs help wiping  
Uses incontinent briefs: All day Nights only  
Men only: Sits to urinate Stands to urinate  
Has toileting schedule. Explain schedule: \_\_\_\_\_  
How does he/she communicate when they need to use the restroom? \_\_\_\_\_  
Comments: \_\_\_\_\_

**BEHAVIOR:**

Level of supervision required for time at camp (Please check only one)  
Can function independently and in a group with little supervision  
Needs some supervision, functions in a group of 2-4  
Benefits from one-to-one supervision throughout the day  
Further explanation or comments: \_\_\_\_\_

**Activity level:**

Has typical attention span for his/her age [or] Has a short attention span/is easily distracted  
Is underactive (needs motivation to participate) [or] Is overactive (needs help calming to participate)  
Please describe how you manage his/her activity level, encourage him/her to participate, etc.  
\_\_\_\_\_

BEHAVIOR	NEVER	SELDOM	OFTEN	EXPLAIN/DETAILS
Stubborn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Self-abusive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hits, scratches, pinches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Uses inappropriate words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Yelling/disruptive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prefers to be alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Describe approaches to be used with difficult behavior. (Camp staff are not specifically trained to deal with challenging behaviors. If this is an area of concern for an individual, please contact Camp Phillip.):

What typically triggers challenging behaviors? \_\_\_\_\_  
 What are two or three effective rewards? \_\_\_\_\_

Has the applicant ever been away from home: Yes No Is homesickness anticipated: Yes No  
 If Yes, how can we assist with the transition? \_\_\_\_\_

**LEISURE TIME ACTIVITIES:** (What does the camper do for fun at home or like best about camp?)

Hobbies/interests: \_\_\_\_\_  
 What are some favorite outdoor activities? \_\_\_\_\_  
 What are some favorite indoor activities? \_\_\_\_\_

Does the camper enjoy: Rowboats/canoe Fishing Sitting by the water  
Crafts/coloring Singing/dancing Nature Playground Outdoor games  
Puzzles Reading Board games \_\_\_\_\_ Card games \_\_\_\_\_

Swimming: Independent Uses life vest Plays near edge  
 Doesn't swim but likes to: Dangles toes Observes others Would not like being near water

**MEALTIME:** Staff will make every effort to adhere to diets. However, they may not be able to keep strict reducing diets. If there are special requirements, please send food with camper.

Diet: \_\_\_\_\_  
 May the camper deviate from their diet, or portions of it, during camp? Yes No  
 If yes, specify: \_\_\_\_\_  
 Consistency: **Solids:** Regular Pureed **Liquids:** Thin Thickened--Please provide thickener.  
 Does the camper use special cup/utensils? No Yes--If Yes, please send.  
 Food likes: \_\_\_\_\_  
 Food dislikes: \_\_\_\_\_  
Eats independently Needs food cut Needs total assistance  
Has difficulty with choking or swallowing \_\_\_\_\_  
 Appetite: Large Medium Small  
 May the camper have seconds within reason? Yes No  
 May the camper drink coffee? Regular Decaf Cup limit? \_\_\_\_\_  
 (Camp only serves coffee during breakfast hours.)

**RELEASES TO BE SIGNED BY THE CAMPER’S GUARDIAN**

Releases **must be signed** by the camper’s guardian (or the camper if they are their own guardian). If the releases are not signed, the camper will not be permitted to attend camp.

**PERMISSION TO ATTEND JESUS CARES CAMP PHILLIP**

Camper name: \_\_\_\_\_

I grant permission for my son/daughter/ward to attend Jesus Cares Camp Phillip. I also give permission for Camp staff to dispense medication to my Camper as detailed in the Camper Registration Packet or communicated to them at the time of the Camper’s arrival at Jesus Cares Camp Phillip. I understand that there are not licensed and trained medical professionals on staff at Jesus Cares Camp Phillip.

Signature (parent or guardian): \_\_\_\_\_

Printed: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT / RELEASE OF LIABILITY**

Camper name: \_\_\_\_\_

To the best of my knowledge, the health information is correct and complete. The person herein described has permission to engage in all camp activities, unless noted otherwise. Authorization for treatment: I hereby give permission to the medical personnel selected by Jesus Cares Camp Phillip to order X-rays, routine tests, treatment, to release any records necessary for insurance purposes, and to provide or arrange necessary related transportation for me or the camper. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Jesus Cares Camp Phillip to secure and administer treatment, including hospitalization, for the person named above.

While camp staff strives to reduce risks to participants, accidents can and do occur. I understand there is risk in retreat activities that are beyond Jesus Cares Camp Phillip control. (In view of the current legal atmosphere, we must inform you that potential accidents in retreat programs may include, but may not be limited to: blisters, insect stings, sunburn, sprains, cuts, bruises, dislocations, fractures, concussion, spinal cord damage or even death.) I agree to personally assume such risks and release JCM or Camp Phillip or other agencies from all liability for injury sustained during the retreat.

Signature (parent or guardian): \_\_\_\_\_

Printed: \_\_\_\_\_ Date: \_\_\_\_\_

**PHOTO / PUBLIC RELATIONS CONSENT AND RELEASE**

I understand that Jesus Cares Ministries and Jesus Cares Camp Phillip may wish to use my/my camper’s name, photograph and/or stories with its work and that it needs appropriate consent to do so. Pictures may be taken for the purpose of sharing with the group, for sharing with area churches, the community and on the JCM or Camp Phillip webpage. I hereby give my permission to Jesus Cares Camp Phillip to use for volunteer recruitment, fundraising and other communications purposes, photographs, films or audio recordings concerning myself/my camper. I hereby warrant that I have the full power to give this consent to sign this release.

Camper name: \_\_\_\_\_

Signature (parent or guardian): \_\_\_\_\_

Printed: \_\_\_\_\_ Date: \_\_\_\_\_



# CAMP PHYSICAL EXAM

*To be completed by a healthcare professional.*

Camper name: \_\_\_\_\_ Date of exam \_\_\_\_\_

Provider name \_\_\_\_\_ Phone \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ P \_\_\_\_\_ T \_\_\_\_\_ R \_\_\_\_\_

1. In my opinion the camp applicant's condition (circle one) **WOULD / WOULD NOT** allow for his/her participation in an active camp program. (Campers will be staying in cabins with no air conditioning.)

2. Primary medical diagnoses: \_\_\_\_\_

3. Allergies: \_\_\_\_\_

4. Does applicant have seizure disorders?  Yes  No

Type/Treatment \_\_\_\_\_

5. Diabetes?  Yes  No      Glucose checks at camp?  Yes  No      Frequency/Instructions \_\_\_\_\_

6. Dietary restrictions while at camp \_\_\_\_\_

**Any conditions related to:**

**History of:**

Eyes	Asthma
Ears	Recent illness
Throat	Kidney disease
Skin	Stomach disorders
Heart	Heart disease
Lungs	Previous surgery
Extremities	Psychiatric illness
Abdomen	Blood/Clotting disorder
Neurologic	

7. Any further recommendations:

EXAMINER'S NAME \_\_\_\_\_ SIGNATURE \_\_\_\_\_