



Dear Parents and Campers,

With the New Year comes a new season of Camps at Camp Aldersgate. We are excited that our Spring Weekend Camps are filling up, and we look forward to what this summer has in store! Registration for the following camps is currently open:

### Weekend Camps

**\*\*Returning summer campers, please note that you may now be able to attend Weekend Camps\*\***

- Weekend residential camping experiences that utilize a strength-based approach to design programming and guide camper placement
- Occur each month throughout the school year (see our website for a calendar and more information)
- Camp Aldersgate has secured partial funding to aid families in covering the tuition. Fees are determined on a sliding scale based on family income.
- Serves campers with special needs, ages 6-18, who meet one of the following criteria:
  1. Eligible for a Camp Aldersgate Summer Camp
  2. Receives special education and "related services" in the school setting
  3. Requires the use of assistive devices and adaptations to complete Activities of Daily Living (ADLs)

### Kota Camps

- Inclusive, week-long and weekend residential camping experiences for children with and without disabilities
- Camp Aldersgate has secured partial funding to aid families in covering the tuition. Fees are determined on a sliding scale based on family income.
- More information regarding the Kota Camps registration process, Financial Disclosure and tuition can be found online or by calling the office.
- The first round of placements for Spring and Summer Kota Camps will be completed March 15<sup>th</sup>, and priority will be given to those who have completed and returned applications by this date. The final deadline for Kota applications is April 16<sup>th</sup>.

### Residential Summer Camps

- Week-long residential camping experiences for campers with specific medical diagnoses
- Offered in collaboration with local health agencies (contact information listed in application)
- Contact the health agency for details regarding camper tuition, fees, and camper scholarships

### Summer Day Camp

- 6-week day camp designed for children with autism spectrum disorder, grades K-8<sup>th</sup>
- Contact A-Camp for information regarding tuition, fees, & scholarships

**We strongly encourage you to complete registration as soon as possible to help ensure your child's participation.** If you need additional copies of applications or have any questions, please just give us a call or visit our website, [www.campaldersgate.net](http://www.campaldersgate.net). **A complete application, including your Physician's Authorization, is necessary to secure placement in any of our programs.**

Sincerely,

The Camp Aldersgate Program Team

Ali Miller Berry

Katie Jenkins

Ian Shuttleworth

Nathan Nelson



MedCamps  
Muscular Dystrophy  
June 9-14, 2019



### Camper Application Checklist

Please use this form as a guide to ensure a completed application is returned. Space for camping sessions is limited.  
**ONLY COMPLETE APPLICATIONS WILL BE CONSIDERED FOR ACCEPTANCE.**

- |     |   |                          |           |
|-----|---|--------------------------|-----------|
| 1.  | <b>Camper Information section</b>   | <input type="checkbox"/> | completed |
| 2.  | <b>Parent/Guardian Information section</b>  | <input type="checkbox"/> | completed |
| 3.  | <b>Emergency Contact Information section</b><br>This section must be completed in full. There must be 2 alternate contacts other than parent/guardian who do not reside in the same household.<br>example: #1 is a neighbor and #2 is the camper's aunt.  | <input type="checkbox"/> | completed |
| 4.  | <b>Parent/Guardian Authorization &amp; Release section</b><br>Parent Authorizations – includes emergency authorization for treatment must be completed and signed by a parent or guardian.  | <input type="checkbox"/> | completed |
| 5.  | <b>Optional Information section</b>   | <input type="checkbox"/> | completed |
| 6.  | <b>Personal Care and Activity Information section</b>   | <input type="checkbox"/> | completed |
| 7.  | <b>Special Instructions and Daily Routines section</b>  | <input type="checkbox"/> | completed |
| 8.  | <b>Insurance Information section</b>  | <input type="checkbox"/> | completed |
| 9.  | <b>Immunization History</b><br><b>First time campers</b> must include a complete copy of their immunization record.<br><br><b>Returning campers</b> need to provide record of any new immunizations since last attending camp. If there have been no immunizations since last attending Camp Aldersgate disregard this section. | <input type="checkbox"/> | attached  |
| 10. | <b>Health History &amp; Physician's Authorization section</b><br>The child's physician (or Advanced Practice Nurse representing the physician) must complete this section and sign the Physician's Authorization portion.   | <input type="checkbox"/> | completed |
| 11. | <b>Camper Code of Conduct</b>   | <input type="checkbox"/> | completed |
| 12. | <b>Respiratory Equipment Form</b><br>This form <b>MUST</b> be completed and returned to Camp Aldersgate if your camper utilizes any respiratory equipment (e.g. BiPAP, C PAP, Cough Assist, etc.) in order for Camp to schedule appropriate medical professionals to best care for every child.                                 | <input type="checkbox"/> | completed |



Please return completed application to:

Camp Aldersgate  
Attn: Applications  
2000 Aldersgate Rd  
Little Rock, AR 72205

**Application Deadline May 16, 2019**

2019 Summer – Camp Aldersgate and MedCamps Partnering Health Agencies

<p><b>Muscular Dystrophy Camp: June 9-14</b>                  Age: 8 to 17                  Contact: Jodie Muenz                  Muscular Dystrophy Association                  Phone: 972.480.0011                  email: jmuenz@mdausa.org                  Camp Physician: Richard Nix, M.D.</p> <p><b>*Campers must also complete online forms through MDA**</b></p>	<p><b>Kidney Camp: July 21-26</b>                  Age: 6 to 18                  Contact: Rick Wilson                  Phone: 501.364.1406                  email: wilsonrc@archildrens.org                  Camp Physician: Saritha Ranabothu, M.D.</p> <p><b>**Download applications on website – Due May 16<sup>th</sup>**</b></p>
<p><b>Spina Bifida Camp: June 16-21</b>                  Age: 6 to 16                  Contact: Brad Caviness                  Arkansas Spinal Cord Commission (ARSCC)                  Phone: 501.296.1788 or 1.800.459.1517                  email: brad.caviness@arkansas.gov                  Camp Physician: Vikki Stefans, M.D.                  Laura Hobart, M.D.</p> <p><b>**Applications available and returned through ARSCC**</b></p>	<p><b>Cardiac Camp: July 21-26</b>                  Age: 6 to 18                  Contact: Angie Smith                  Phone: 501.364.1479                  email: smithangelaj@uams.edu                  Camp Physician: Paul Seib, M.D.</p> <p><b>**Download applications on website – Due May 16<sup>th</sup>**</b></p>
<p><b>Kota Camps: Session I June 23-28</b>  <b>Session II July 7-12</b>                  Inclusive camps for children with various disabilities and their non-disabled siblings and friends.                  Age: 6 to 18                  Contact: Camp Aldersgate                  Phone: 501.225.1444                  email: amiller@campaldersgate.net                  Camp Physicians:                  Session I – Jill Fussell, M.D.                  Session II - Gene France, M.D.</p> <p><b>**Download applications on website – First Selections Will be made on March 16<sup>th</sup>, Final Deadline is May 16<sup>th</sup> **</b></p>	<p><b>Oncology Camp: July 28 – August 2</b>                  Age: 6 to 18                  Contact: Tara DeJohn                  Jennifer Taussig                  Kara Burge                  Phone: 501.364.1494                  501.364.6662                  email: dejohnstv@archildrens.org                  email: taussigjl@archildrens.org                  email: burgekb@archildrens.org                  Camp Physician: Suzanne Saccente, M.D.</p> <p><b>**Download applications on website – Due May 16<sup>th</sup>**</b></p>
<p><b>Diabetes Youth Camp: July 14-19</b>                  Age: 8 to 13                  Contact: Nicole Matti                  American Diabetes Association                  Phone: 248.4333.3830 ext. 6706                  email: nmatti@diabetes.org                  Camp Physician: Jon Oden, M.D.</p> <p><b>**Download applications on website – Due May 16<sup>th</sup>**</b></p>	<p><b>Bleeding Disorders Camp: July 28 – August 2</b>                  Age: 6 to 18                  Contact: Kara Burge                  Arkansas Center for Bleeding Disorders                  Phone: 501.364.6662                  email: burgekb@archildrens.org                  Camp Physician:</p> <p><b>**Download applications on website – Due May 16<sup>th</sup>**</b></p>
<p><b>Arthritis Camp AcheAway: July 21-26</b>                  Age: 6 to 16                  Contact: Emily Pearce                  Arthritis Foundation                  Phone: 501.232.7298                  email: epearce@arthritis.org                  Camp Physician: Jason Dare, M.D.</p> <p><b>**Download applications on website – Due May 16<sup>th</sup>**</b></p>	<p><b>A-Camp: June 10 – August 1</b>                  Inclusive Day Camp designed for children with ASD                  6 Week Program; Monday – Thursday Weekly*                  Contact: Camp Aldersgate                  Phone: 501.225.1444                  email: nnelson@campaldersgate.net</p> <p>No camping session July 1 – 4  <b>**Notification of availability of applications will be made on website and social media**</b></p>

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# MedCamps Muscular Dystrophy Camp June 9-14, 2019

Attach  
Recent  
Photo  
Here

## Camper Application

Date of this application: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please indicate the program and year your child last attended: New Camper\_\_\_\_ Summer Camps yr.\_\_\_\_ Weekend Camps yr.\_\_\_\_

### CAMPER INFORMATION

Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle

Gender: (circle) male female T-shirt size: \_\_\_\_\_

Where is your child's primary residence? \_\_\_\_with both parents \_\_\_\_with mother \_\_\_\_with father \_\_\_\_with guardian

Primary Medical Diagnosis/Condition (if not applicable write "none"): \_\_\_\_\_

List any Secondary Diagnoses/Conditions: \_\_\_\_\_

How did you hear about Camp Aldersgate's camping programs? \_\_\_\_\_

If possible, this applicant would like to be assigned with the following cabinmate(s): \_\_\_\_\_

### PARENT / GUARDIAN INFORMATION

**Mother or Guardian** Job Title: \_\_\_\_\_

Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Last First

Telephone Numbers: Home \_\_\_\_/\_\_\_\_ Work \_\_\_\_/\_\_\_\_

Cell \_\_\_\_/\_\_\_\_ Email: \_\_\_\_\_

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

County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Father or Guardian** Job Title: \_\_\_\_\_

Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Last First

Telephone Numbers: Home \_\_\_\_/\_\_\_\_ Work \_\_\_\_/\_\_\_\_

Cell \_\_\_\_/\_\_\_\_ Email: \_\_\_\_\_

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

County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Who will be the primary contact while your child is at camp? (circle) Mother Father other \_\_\_\_\_

Best phone number to call: \_\_\_\_/\_\_\_\_

If unable to reach parent/guardian, please notify: (Two different individuals not living in the same household are required.)

1) Full Name: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_

Daytime telephone: \_\_\_\_/\_\_\_\_ Evening telephone: \_\_\_\_/\_\_\_\_

2) Full Name: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_

Daytime telephone: \_\_\_\_/\_\_\_\_ Evening telephone: \_\_\_\_/\_\_\_\_

PARENT / GUARDIAN AUTHORIZATION

The following authorization **MUST** be signed before applicant can be accepted as a camper.

The health history I have provided in this application is correct and complete as far as I know. I agree to inform the camp of any significant health related issues that may arise following submission of this application and prior to my child's/ward's participation in the camp's programs and understand additional information and/or physician authorization may be requested. I give permission to Camp Aldersgate, Inc. to provide routine health care, administer prescribed medications, and seek emergency medical treatment including x-rays or routine tests for my child/ward :**(name of camper)**\_\_\_\_\_.

I give permission for my child/ward (named above) to participate in the programs at Camp Aldersgate, Inc., in all camp activities, including field trips away from camp, except as noted by the physician or parent/guardian. I hereby release Camp Aldersgate, Inc., its Board of Directors, employees, volunteers, collaborating agencies, physicians, agents, independent contractors, and any and all parties of interest from all claims, demands, grievances and causes of action of every kind whatsoever, including, but not limited to, all which may arise from or out of any injury incurred by my child/ward (named above) while in attendance at the camp. This includes any necessary transportation.

In the event I cannot be reached in an emergency, I give permission to the physician selected by Camp Aldersgate, Inc. to secure and administer any necessary treatment, including hospitalization for my child/ward (named above). I give permission to Camp Aldersgate, Inc. to arrange necessary related transportation for my child/ward (named above).

I give permission for Camp Aldersgate, Inc. staff to administer over-the-counter medications for my child/ward (named above) if the camp medical staff deems it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise.

I agree to the release of any records necessary for insurance purposes and give permission for Camp Aldersgate, Inc. personnel to receive information concerning my child/ward (named above) from various medical, therapeutic, and other professionals which may be necessary for participation in Camp Aldersgate, Inc. programs.

I grant full permission and authority to Camp Aldersgate, Inc., its collaborating agencies, and their representatives to photograph my child/ward (named above) and to use, publish, and release for publication such photos relating to the programs of the above named organizations. The name of my child/ward may be used in connection with the above, with the understanding that there is to be no exploitation of the family member and that any photographs so used should conform to standards of good taste. This form may be photocopied for use outside of camp. My signature below indicates that I have read and agree with all the statements of the Parent Authorization.

Camp Aldersgate may not be able to accommodate all medical conditions and/or disabilities. Camp Aldersgate reserves the right to make the final decision regarding admittance and dismissal of participants to its programs. This policy is to insure that adequate provisions can be made for participants while they are in the care of the camp.  
Camp Aldersgate serves those who do not: require personal caregivers other than camp staff or engage in aggressive and/or abusive behavior. Campers are recruited on a non-discriminatory basis, without regard to race, color, creed, sex, gender identification, national origin, religious or political affiliation.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

OPTIONAL INFORMATION

The following section is information used solely for gathering statistical information and obtaining grant funding. Omission of any or all questions will not affect the status of your application. This assists Camp Aldersgate in securing funding to lower program costs. Answer questions as they pertain to your child and his/her household.

Ethnic Origin: (circle one) Black/African American Asian White American Indian Hispanic/Latino Other: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_

Household Information: (circle one) two parent one parent

Number of Children, not including camper, living in household: \_\_\_\_\_

Household Annual Income: (circle one) less than \$25,000 \$25,001-\$35,000 \$35,001-\$50,000  
\$50,001-\$75,000 \$75,001-\$100,000 \$100,001+

Camper Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PERSONAL CARE AND ACTIVITY INFORMATION**

The following specific applicant information is to be completed by parent/guardian for camp medical staff. A copy will be given to the applicant's counselors. Please attach any additional information necessary to assist the counselors and volunteers to care for your child.

Does the camper like to be called by any other name? \_\_\_\_\_ Age during camp: \_\_\_\_\_

Current grade in school: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: (circle) male female

Please indicate (✓) the level of assistance needed for the following daily activities

Personal Care Activity	needs no assistance	minimal assistance	total assistance	notes/needs	
brushing teeth					
showering					
dressing					
hair brushing					
transfer (to and from wheelchair)					
Camp Activity	needs no assistance	minimal assistance	total assistance	should not participate	notes/needs
swimming					
SCUBA					
fishing					
canoeing/boating					
outdoor sports and games					
archery					
adventure challenge activities (ropes course)					
nature trails					
arts/crafts					

Please circle/write the appropriate information below (attach additional page if needed)

**Ambulation:** wheelchair: *manual* *electric* walker  
 crutches braces walks alone - no devices  
**wanders?** yes no occasionally

**Sleeping:** no problems needs help turning over  
 needs help getting in or out of bed needs bed rails  
 wets bed wears diapers at night walks in sleep  
 usual sleep time: from \_\_\_\_\_ p.m. to \_\_\_\_\_ a.m.

**Behavior:** no problems use time out (minutes: \_\_\_\_\_)  
 problems triggered by: \_\_\_\_\_  
 positive reinforcers: \_\_\_\_\_  
 suggestions: \_\_\_\_\_

**Toilet Management:** no problems diapers training pants  
 catheterization every \_\_\_\_\_ hours self-catheterization  
 catheter size \_\_\_\_\_ brand \_\_\_\_\_ type \_\_\_\_\_  
 usually has bowel movement every \_\_\_\_\_ day(s)  
 needs help with: \_\_\_\_\_

What does the applicant take for pain/discomfort:  
 \_\_\_\_\_

**Eating:** no assistance needed at meals regular diet  
 G-Tube NG-Tube tube feedings every \_\_\_\_\_ hours  
 food must be: cut chopped mashed pureed  
 must be fed special utensils: \_\_\_\_\_  
 needs help with: \_\_\_\_\_  
 special diet: \_\_\_\_\_

**Seizures:** none has seizures date of last one \_\_\_\_\_  
 Type \_\_\_\_\_  
 usual duration \_\_\_\_\_ usual frequency \_\_\_\_\_  
 triggered by \_\_\_\_\_

**Communication:** no problems non-verbal sign language  
 limited abilities can communicate personal care needs  
 communication device (type \_\_\_\_\_)

**Hearing:** no problems oral deaf  
 hearing impaired wears aides

**Vision:** normal wears glasses limited blind

**Heat Tolerance:** good fair poor

SPECIAL INSTRUCTIONS AND DAILY ROUTINES

Camp Aldersgate strives to make each camper’s participation a safe, comfortable, and fun experience. It is important that we have as much information as possible regarding what your child is used to and comfortable with. Sometimes following routines or special ways of doing things helps a camper feel more at ease with a new environment. Please take a few moments and share with us your child’s typical daily routine (especially consistent behavior problems, as well as personal care and mealtime procedures) and include any special instructions, techniques of motivating and rewarding your child, hobbies, likes/dislikes, etc. Everything that you provide will help us better care for your child.(example: My child will only settle down at night if I rock her. She will smile each morning if I hum a song to her.) Also include any goals you would like the applicant to achieve during their stay at camp.(examples: improve personal care skills, make new friends, learn to float in pool, etc.) Enclose extra pages if necessary.

Multiple horizontal lines for writing.

INSURANCE INFORMATION

Name of carrier: \_\_\_\_\_ Policy or Group #: \_\_\_\_\_
Medicaid #: \_\_\_\_\_ Hospital preference in Little Rock (if any): \_\_\_\_\_
Name of Primary Care Physician: \_\_\_\_\_
Physician’s office phone: (\_\_\_\_\_) \_\_\_\_\_ Physician’s emergency phone: (\_\_\_\_\_) \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

IMMUNIZATION HISTORY

We are required to have a copy of each camper’s immunization record on file.

New campers at Camp Aldersgate - a complete copy of his/her immunization record MUST accompany this application.

Returning campers - all we need is a record of any immunizations received since last at Camp Aldersgate. If your child has not received any new immunizations, disregard this section.

Applications submitted without the required immunization information cannot be processed until this information is received. Camp Aldersgate adheres to immunization guidelines used by most educational facilities.

Please check with your school nurse or administration about obtaining a copy of your child’s record.



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

Date of Birth: \_\_\_\_\_

**HEALTH HISTORY AND PHYSICIAN'S AUTHORIZATION**

*The Health History and Physician's Authorization (both sides of this form) is to be completed by the applicant's Primary Care Physician. It will be used by the camp's medical staff to determine medical eligibility, be reviewed by the camper's counselors, and will be kept on file in the infirmary.*

Dear Physician,

Camp Aldersgate's Camping Programs feature 3 to 6 days of traditional camping activities for children with medical conditions, physical disabilities, and developmental delays. Accepted applicants will be assigned to live with 6 to 8 cabin mates as well as junior and senior counselors. Activities may include nature hikes, canoeing, fishing, swimming, SCUBA, archery, campfires, music, adventure/challenge (ropes course) activities, arts and crafts. Although activities have been adapted so children of all abilities can participate, they may require physical exertion and/or travel to and from various locations throughout the camp.

Please complete both sides of this form. Attach additional information you feel the camp medical staff should be aware of.

Primary Medical Diagnosis: *(if not applicable write "none")* \_\_\_\_\_

List any Secondary Diagnoses: \_\_\_\_\_

CURRENT MEDICATION(S) <small>(please indicate if pill, inhaler, injection, etc.)</small>	STRENGTH	DOSAGE	TIME(S)			
			breakfast	lunch	dinner	other

**ALLERGY INFORMATION**

Is this child allergic to any:

<b>Medications</b>	Name	Reaction (be specific)	Age of last reaction
<b>Foods</b>	Name	Reaction (be specific)	Age of last reaction
<b>Animals</b> <b>Insects</b> <b>Plants</b>	Name	Reaction (be specific)	Age of last reaction
<b>Other</b>	Name	Reaction (be specific)	Age of last reaction

Is this child latex sensitive?                      yes                      no

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

Date of Birth: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

height: \_\_\_\_\_

weight: \_\_\_\_\_

blood pressure: \_\_\_\_\_/\_\_\_\_\_

heart rate: \_\_\_\_\_

respiration rate: \_\_\_\_\_

**PHYSICAL EXAMINATION**

Body System	normal	abnormal	If abnormal, please explain
HEENT			
Cardiovascular			
Respiratory			
Gastrointestinal			
Skeleto-muscular			
Genitourinary			
Other – please explain			

Please circle/write the appropriate information below

**General:** frequent ear infections heart defect/disease seizures bleeding/clotting disorders hypertension rashes/ringworm  
comments regarding circled items: \_\_\_\_\_

**Surgeries** (specify): \_\_\_\_\_

**Childhood Diseases:** chicken pox mumps measles german measles other (specify): \_\_\_\_\_

**For Female Applicants** - Has this applicant menstruated? yes no If so, is her menstrual history normal? yes no

Special consideration: \_\_\_\_\_

**Medical Equipment**

wheelchair charger hearing aids dialysis cyclor other: \_\_\_\_\_

Bi-PAP C-PAP ventilator inhaler hospital bed other: \_\_\_\_\_

**Has Down syndrome been diagnosed in this applicant?** yes no

If yes, is the applicant clear of Atlantoaxial Dislocation Condition confirmed by diagnostic x-ray? yes no

**Restrictions/limitations on participation in any camp activities:** \_\_\_\_\_

**Additional Comments:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PHYSICIAN'S AUTHORIZATION**

I have examined \_\_\_\_\_ within the past 6 months (date examined: \_\_\_\_\_) and in my opinion, his/her condition **DOES NOT** preclude his/her participation in an active camp program.

Physician's Printed Name: \_\_\_\_\_ Phone: \_\_\_\_\_/\_\_\_\_\_

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

Licensed Physician Signature (or Advanced Practice Nurse/Registered Nurse Practitioner representing the physician):

X \_\_\_\_\_ Date: \_\_\_\_\_

## CAMPER CODE OF CONDUCT

*(Please review with your child)*

It is our hope that everyone that participates in our program will have a positive experience that will last a lifetime. To help everyone get the most out of their camp experience, we have set up a list of ground rules to help parents and children understand what we expect at camp. We recognize the special needs of our campers and will, as much as possible, individualize the rules according to the needs and abilities of each camper.

Camp has four basic rules that we explain to the children and also post in the cabins. We have these rules so that everyone can be assured of a positive experience.

- **Respect yourself, others and property.** Abusiveness toward others or using inappropriate language, fighting, stealing, etc. is not allowed. It also covers property damage, graffiti or vandalism. Respect yourself, refers to keeping your things picked up, personal hygiene and taking your medication on time.
- **Participate in camp activities.** It is camp's responsibility to know where all the campers are at all times. We encourage campers to try all activities unless excused by staff. Campers are supervised at all times and cannot be left alone.
- **Follow directions.** There are a lot of fun things to do at camp but every activity has rules so we can operate the activity safely and appropriately. We ask the campers to follow staff direction during these activities.
- **No put-downs.** Examples of this would include teasing, name-calling, racial slurs or inappropriate practical jokes.

If we do have a problem with inappropriate behavior, we have a camper behavior response policy. The counselor will start by giving the child a warning, and then a time-out with an explanation and discussion on what is causing the problem. If the counselor needs help, a supervisor or coordinator on site will work with the child to help avoid further problems. We will also call home to find out if the parents have any suggestions on ways to deter the inappropriate behavior. As a last resort, we may need to send a child home. Sometimes in the case of severe homesickness or if misbehavior could cause immediate harm to themselves or others, we reserve the right to immediately ask that the child be removed from camp.

It is our hope that each child will go home with great memories of camp. These rules are designed to protect the camper's experience so that one unruly child won't ruin the experience for the rest. If you have any questions or comments, please feel free to call. It is our mission to provide a quality experience for everyone.

**I understand and accept that my child must abide by the Camper Code of Conduct**

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

**I agree to abide by the Camper Code of Conduct**

Camper's Signature \_\_\_\_\_ Date \_\_\_\_\_

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Dear Parent - If your camper currently uses respiratory equipment, our medical team is requesting your cooperation in acquiring additional information. Please complete this form and return to Camp Aldersgate (2000 Aldersgate Rd., Little Rock, AR 72205) as soon as possible to insure we are able to adequately meet your needs.

CAMPER NAME: \_\_\_\_\_ CAMP SESSION: \_\_\_\_\_

RESPIRATORY ISSUES

Do you have difficulty breathing? (circle one) YES NO If yes, please explain \_\_\_\_\_

Oxygen Requirement? (circle one) YES NO

When do you use oxygen? All the time \_\_\_\_\_ At night \_\_\_\_\_ During the day \_\_\_\_\_ As needed \_\_\_\_\_

How many tanks will you need at camp? \_\_\_\_\_

BiPap/CPap Requirement? (circle one) YES NO When do you use it? night \_\_\_\_\_ nap time \_\_\_\_\_ other \_\_\_\_\_

Ventilator Dependent? (circle one) YES NO When do you use it? \_\_\_\_\_

Do you have a trach? (circle one) YES NO Size of trach: \_\_\_\_\_

CARDIAC ISSUES

Any diagnosed cardiac problems? (circle one) YES NO If yes, please explain \_\_\_\_\_

Do you have a history of high blood pressure? (circle one) YES NO If yes, please explain \_\_\_\_\_

Do you have a history of clotting or bleeding problems? (circle one) YES NO If yes, please explain \_\_\_\_\_

RESPIRATORY EQUIPMENT

If you need respiratory equipment at camp, it is your responsibility to make sure you have sufficient equipment for the entire camp session (6 days). If your equipment is provided by a Medical Supply company please provide –

company name: \_\_\_\_\_; phone #: \_\_\_\_\_

BiPap Machine \_\_\_\_\_

CPAP Machine \_\_\_\_\_

IPAP \_\_\_\_\_

Pressure setting \_\_\_\_\_

EPAP \_\_\_\_\_

Rate (if applicable) \_\_\_\_\_

Ventilator Type (circle one) LTV950 LTV1150 LTV other model # \_\_\_\_\_ Trilogy Other \_\_\_\_\_

Ventilator settings Mode (choose one) A/C SIMV

Rate \_\_\_\_\_ Tidal volume \_\_\_\_\_ OR Pressure control \_\_\_\_\_ PEEP \_\_\_\_\_ Pressure support (only for SIMV) \_\_\_\_\_

Inspiratory time \_\_\_\_\_ Sensitivity \_\_\_\_\_ High pressure alarm \_\_\_\_\_ Low pressure alarm \_\_\_\_\_

Low minute volume \_\_\_\_\_ Other \_\_\_\_\_

Suction Machine \_\_\_\_\_ Size of suction catheters \_\_\_\_\_

Cough assist device \_\_\_\_\_ How often \_\_\_\_\_ Settings \_\_\_\_\_

Vest \_\_\_\_\_ How often \_\_\_\_\_ Settings \_\_\_\_\_

IPV \_\_\_\_\_ How often \_\_\_\_\_ Settings \_\_\_\_\_

Manual CPT \_\_\_\_\_ How often \_\_\_\_\_