Camper Name _____

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 17th, and priority will be given to those who have completed and returned applications by this date. The final deadline for Kota applications is May 15th.

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

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. **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 Katie Jenkins Ian Shuttleworth

Camper Name _____

MedCamps
Muscular Dystrophy
June 7-12, 2020
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. Camper Information section ☐ completed

2. Parent/Guardian Information section ☐ completed

3. Emergency Contact Information section ☐ completed
   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.
   example: #1 is a neighbor and #2 is the camper's aunt.

4. Parent/Guardian Authorization & Release section ☐ completed
   Parent Authorizations – includes emergency authorization for treatment must be completed and signed by a parent or guardian.

5. Optional Information section ☐ completed

6. Personal Care and Activity Information section ☐ completed

7. Special Instructions and Daily Routines section ☐ completed

8. Insurance Information section ☐ completed

9. Immunization History ☐ attached
   First time campers must include a complete copy of their immunization record.

   Returning campers 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.

10. Health History & Physician's Authorization section ☐ completed
    The child's physician (or Advanced Practice Nurse representing the physician) must complete this section and sign the Physician's Authorization portion.

11. Camper Code of Conduct ☐ completed

12. Respiratory Equipment Form ☐ completed
    This form **MUST** 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.

Please return completed application to:

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

Application Deadline: May 15, 2020

Camper Name _____

2020 Summer – Camp Aldersgate and MedCamps Partnering Health Agencies

Muscular Dystrophy Camp: June 7-12 Age: 8 to 17 Contact: Brooke Smith, LMSW Muscular Dystrophy Association Phone: 501.289.0656 email: brsmith@mdausa.org Camp Physician: Richard Nix, M.D. **Applications available and returned through MDA**	**Kidney Camp: July 19-24** Age: 6 to 18 Contact: Rick Wilson Phone: 501.364.1406 email: wilsonrc@archildrens.org Camp Physician: Saritha Ranabothu, M.D. **Download applications on website – Due May 15th**
Spina Bifida Camp: June 14-19 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. **Applications available for download on website or through ARSCC. Due May 15**	**Cardiac Camp: July 19-24** Age: 6 to 18 Contact: Angie Smith Phone: 501.364.1479 email: smithangelaj@uams.edu Camp Physician: Paul Seib, M.D. **Download applications on website – Due May 15th**
Kota Camps: Session I June 21-26 **Session II July 5-10** 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. **Download applications on website – First Selections Will be made on March 17th, Final Deadline is May 15th **	**Bleeding Disorders Camp: July 26-31** Age: 6 to 16 Contact: Kara Burge Arkansas Center for Bleeding Disorders Phone: 501.364.1494 email: kburge@archildrens.org Camp Physician: Suzanne Saccente, M.D. **Download applications on website – Due May 15th**
Diabetes Youth Camp: July 12-17 Age: 7 to 13 Contact: Nicole Matti American Diabetes Association Phone: 248.4333.3830 ext. 6706 email: nmatti@diabetes.org Camp Physician: Jon Oden, M.D. **Download applications on website – Due May 15th**	**Oncology Camp: July 26-31** Age: 6 to 16 Contact: Tara DeJohn Jennifer Taussig Phone: 501.364.1494 email: dejohntv@archildrens.org email: taussigjl@archildrens.org Camp Physician: Suzanne Saccente, M.D. **Download applications on website – Due May 15th**
Arthritis Camp AcheAway: July 19-24 Age: 6 to 17 Contact: Emily Pearce Arthritis Foundation Phone: 501.232.7298 email: epearce@arthritis.org Camp Physician: Jason Dare, M.D **Download applications on website – Due May 15th**	

Camper Name _____

(This page to be left blank)

Camper Name _____

Attach Recent Photo Here

CAMP ALDERSGATE
COMMON GROUND FOR EXTRAORDINARY PEOPLE

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:_____ Child's School:_____

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):_____

Applying with **(only for Kota Camp *"paired applicants"*)**:_____

PARENT/GUARDIAN INFORMATION

Mother or Guardian

Job Title:_____

Name:_____
Last First

Employer:_____

Telephone Numbers: Home_____/_____ Work_____/_____

Cell _____/_____ Email address:_____

Address:_____ City:_____

County:_____ State:_____ Zip:_____

Father or Guardian

Job Title:_____

Name:_____
Last First

Employer:_____

Telephone Numbers: Home_____/_____ Work_____/_____

Cell _____/_____ Email address:_____

Address:_____ City:_____

County:_____ State:_____ Zip:_____

EMERGENCY CONTACT INFORMATION

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:_____/_____

Camper Name _____

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

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 caregiviers 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.

Parent Authorization.

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 _____

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

Camper Name _____

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.

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 _____

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) (please indicate if pill, inhaler, injection, etc.)	STRENGTH	DOSAGE	TIME(S)			
			breakfast	lunch	dinner	other

ALLERGY INFORMATION

Is this child allergic to any:

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

Is this child latex sensitive? yes no

Camper Name _____

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 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 cycler 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 <u>DOES NOT</u> 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 Name _____

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 _____

Camper Name _____

(This page to be left blank)

Camper Name _____

RESPIRATORY EQUIPMENT FORM

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 #_____ LP10 Other _____

LTV 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 _____

LP10 settings Mode (choose one) A/C SIMV

Rate _____ Tidal volume _____ Pressure limit/pressure plateau (if applicable) _____ PEEP _____

Inspiratory time _____ Sensitivity _____ High pressure alarm _____ Low pressure alarm _____ Other _____

Other model ventilator settings Mode _____ Rate _____ Tidal volume _____ Pressure control _____

PEEP _____ Pressure support _____ Inspiratory time _____ Sensitivity _____ High pressure alarm _____

Low pressure alarm _____ 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_____