

**CAMP BEAUSITE NORTHWEST**

**2012 CAMPER APPLICATION**

**Return to:** **CAMP BEAUSITE NORTHWEST** (formerly NW Kiwanis Camp)  
P.O. Box 1227  
Port Hadlock, WA 98339

<b>[For Administration use only]</b>		
Date Received: _____	Session: _____	Deposit Amnt _____
Financial Assistance Awarded: _____	Source: _____	
Balance Due: _____	Notes: _____	
DDD Auth. Rec'd: Y ___ N ___	Ins/Med. Coupon Rec'd: Y ___ N ___	
Health Exam Rec'd: Y ___ N ___	Medication Form Rec'd: Y ___ N ___	
Photos Authorized: Y ___ N ___	Field Trip Author. Rec'd: Y ___ N ___	
Dietary Questionnaire Rec'd: Y ___ N ___		
Art Show Author. Rec'd: Y ___ N ___	Confirmation Packet Emailed: _____	

Questions? Please call 360-732-7222 or email us at [admin@campbeausite.org](mailto:admin@campbeausite.org)

This confidential application must be completed in FULL for all campers and will be returned if incomplete. Each applicant will be assessed on an individual basis with consideration given to special circumstances. Acceptance is based upon the review of all required information. The Program Director and Nursing Director reserve the right to refuse or cancel enrollment of any applicant. Cost: \$700.00 per camper, per session. A \$50.00 deposit must accompany the application, payment in full is due no later than June 8, 2012.

**Sessions: Please check the appropriate session based on the age of the camper as of July 1st.**

- \_\_\_\_\_ Session #1 (ages 18 through 35).....Noon June 25, 2012 to Noon June 29, 2012
- \_\_\_\_\_ Session #2 (ages 36 and older) .....Noon July 9, 2012 to Noon July 13, 2012
- \_\_\_\_\_ Session #3 (ages 6 through 17).....Noon July 16, 2012 to Noon July 20, 2012
- \_\_\_\_\_ Session #4 (ages 6 through 17).....Noon July 23, 2012 to Noon July 27, 2012

**Full Name:** \_\_\_\_\_ **Birth date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Email:**(required for notices and forms) \_\_\_\_\_ **Age as of July 1st** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **County:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

**Group Living Facility** (if applicable) \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

**Sex:** M or F (circle) **Race:** \_\_\_\_\_ **Custody Status:** Independent  Parent  Other

**Disability: Primary** \_\_\_\_\_ **Secondary:** \_\_\_\_\_

**Other issues?** \_\_\_\_\_

**Parent/Guardian/Spouse Name:** \_\_\_\_\_

**Address (if different)** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

**Place of Employment** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

**Emergency Contacts** (Other than above)

1. **Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Day Phone:** (\_\_\_\_) \_\_\_\_\_ **Night Phone:** (\_\_\_\_) \_\_\_\_\_

2. **Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Day Phone:** (\_\_\_\_) \_\_\_\_\_ **Night Phone:** (\_\_\_\_) \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

**Health Insurance Carrier:** \_\_\_\_\_ **Policyholder:** \_\_\_\_\_ **Policy#:** \_\_\_\_\_

**Person/Agency responsible for payment:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

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

**If using DSHS or other agency funding, a letter or email verifying your benefits must be received from your Case Manager by June 1st. Due to privacy issues, we do not contact DSHS directly.**

**Please Indicate Shirt Size (check child/adult, circle one size):** [CHILD] \_\_\_ S M L [ADULT] \_\_\_ S M L XL XXL

*Financial assistance through Camp Beausite NW is limited to \$250.00 per camper. Please attach a note to request an application.*

**CAMP BEAUSITE NORTHWEST**

**2012 CAMPER APPLICATION  
DAILY LIVING INFORMATION**

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

**Nickname:** \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Date of last height and weight check:** \_\_\_\_\_

**Approx. Cognitive Age (school grade/age appropriate):** \_\_\_\_\_

**Approx. Functional Age (daily living skills/age appropriate):** \_\_\_\_\_

**HEARING:** Does the Camper have normal hearing? Yes \_\_\_\_\_ No \_\_\_\_\_ **Percentage of hearing loss:** \_\_\_\_\_

If "NO", please tell us what the issue is and how we can work with the camper. \_\_\_\_\_  
\_\_\_\_\_

**SPEECH:** Does the camper use normal English Language? Yes \_\_\_\_\_ No \_\_\_\_\_

If "NO", please tell us what form of language your camper uses and how we might best communicate with the camper:  
\_\_\_\_\_  
\_\_\_\_\_

**Does the camper use an AAC Device? If so, which one?** \_\_\_\_\_ **PEC Boards?** \_\_\_\_\_

If yes, please bring the boards and/or devices as we do not have a supply of devices on hand.

**DIETARY:** Is the camper allergic to any foods: If yes, please list: \_\_\_\_\_

Is the camper on a special diet? Yes \_\_\_\_\_ No \_\_\_\_\_ Is the camper tube-fed? Yes \_\_\_\_\_ No \_\_\_\_\_

**VISION:** Does the camper have normal Vision? Yes \_\_\_\_\_ No \_\_\_\_\_ **Wears glasses?** Yes \_\_\_\_\_ No \_\_\_\_\_

If "No", please tell us the degree of loss: \_\_\_\_\_

**MOBILITY:** Does the camper use a device that helps with mobility? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list the devices the camper uses (ex. wheelchair, walker, other, etc.) \_\_\_\_\_  
\_\_\_\_\_

**Note:** Mobility device(s) must be brought to camp with you.

**TRANSFERS:** Does the camper need transfer assistance? Yes \_\_\_\_\_ No \_\_\_\_\_

If "Yes", what kind of assistance is needed: \_\_\_\_\_  
\_\_\_\_\_

**Will the camper bring adaptive devices or equipment with him/her to camp? Please check all that apply.**

- |                  |               |                              |                |                |
|------------------|---------------|------------------------------|----------------|----------------|
| None _____       | Braces _____  | Night Braces _____           | Splint _____   | Retainer _____ |
| Prosthesis _____ | Glasses _____ | Hearing Aid _____            | Dentures _____ | C-PAC _____    |
| Shunt _____      | Helmet _____  | Car Seat/Booster Seat: _____ | Other _____    |                |

**TOILET:** Is toileting an issue for the camper? Yes \_\_\_\_\_ No \_\_\_\_\_ **Diapers?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Catheter:** Yes \_\_\_\_\_ No \_\_\_\_\_ **Colostomy:** Yes \_\_\_\_\_ No \_\_\_\_\_ **Aids used?** Yes \_\_\_\_\_ No \_\_\_\_\_

If yes please tell us what assistance is required: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WASHING AND DRESSING:** Does the camper need any assistance with washing and dressing? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes what assistance is needed \_\_\_\_\_  
\_\_\_\_\_

**SLEEPING:** Does the camper have difficulty sleeping when away from their usual sleeping environment? Yes \_\_\_\_\_ No \_\_\_\_\_

If "Yes", please explain sleep issues (note – campers sleep outdoors in 12'x 20' tents on elevated platforms):  
\_\_\_\_\_  
\_\_\_\_\_

**HEALTH HISTORY**

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

An individual may not be considered for enrollment if he/she is determined to have a medical condition associated with a high risk for complication or injury.

Does or has the applicant ever had, any of the following: *(record month and year where applicable)*

<b>SEIZURES:</b>	None_____	Petit Mal_____	Grand Mal_____	Other_____
	Severity:_____	Frequency:_____	Most Recent:_____	

	Month/Year		Month/Year		Month/Year
Arthritis		Bleeding Disorder		Chicken Pox	
Ear Infections		Hypertension		Measles	
Heart Defect		Mononucleosis		Rubella	
Diabetes		Decubitis Ulcer		Mumps	

Is the applicant subject to any of the conditions listed (circle those that apply):

Ears	Eyes	Nose	Throat	Nails	Scalp	Skin
Skeletal	Constipation	Abdomen	Heart	Stomach Upset	Kidneys	Lungs

Recommendations: \_\_\_\_\_

<b>ALLERGIES:</b>	<b>Type</b>	<b>Mild</b>	<b>Severe</b>
Drugs			
Insects			
Pollens			
Foods			
Asthma			

*If reaction occurs:* \_\_\_\_\_

**IMMUNIZATION HISTORY**

*(Write month/year of basic immunization, and most recent booster, or you must write "current" or "dates unknown" and initial)*

	<b>Date</b>		<b>Date</b>		<b>Date</b>
DPT		Rubella		T.B. Test	
Polio		Small Pox		Mumps	
Measles		Tetanus		Hepatitis B	

**SURGERIES/SERIOUS ILLNESS** (give dates):

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

CHRONIC OR RECURRING ILLNESS:

\_\_\_\_\_  
\_\_\_\_\_

OTHER CONDITIONS OR ISSUES WE SHOULD BE AWARE OF?

\_\_\_\_\_  
\_\_\_\_\_

Is the camper a “runner”? Yes \_\_\_\_\_ No \_\_\_\_\_

Is the camper taking any prescription medications or over-the counter medications? Yes \_\_\_\_\_ No \_\_\_\_\_

**Please list all medications (prescription and over-the-counter) currently taken:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please Note: The Medication Authorization Form must be completed and signed by your camper’s physician for any medications the camper will be taking during camp sessions.

**ALL PRESCRIPTION MEDICATIONS BROUGHT TO CAMP MUST BE IN THE ORIGINAL CONTAINERS WITH THE PRESCRIBING DOCTOR’S NAME, CAMPER’S NAME, MEDICATION NAME AND DISPENSING INSTRUCTIONS CLEARLY VISIBLE. PHARMACY BLISTER PACKS ARE ACCEPTABLE PROVIDED ALL INFORMATION IS CLEARLY VISIBLE.**

**ALL NON-PRESCRIPTION (Over-The-Counter) MEDICATIONS (INCLUDING VITAMINS, SUPPLEMENTS AND HERBAL REMEDIES) MUST BE IN THE ORIGINAL CONTAINER. THE CONTAINER MUST HAVE A VALID DATE OF EXPIRATION AND HAVE THE CAMPER’S NAME CLEARLY MARKED ON THE CONTAINER.**

**PLEASE DO NOT PACK INTO DAILY PILL BOXES.**

**EXPIRED MEDICATIONS WILL NOT BE ACCEPTED OR ADMINISTERED.**

Please verify that the quantities you bring to camp are sufficient for five days as we cannot process refills.

PERSONAL CAMPER INFORMATION

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

Activities to be encouraged:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Activities to be limited:

\_\_\_\_\_  
\_\_\_\_\_

**A camper-counselor ratio of one-on-one is not guaranteed.**

Does the camper require one-on-one total care and supervision? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Note: At managements' discretion, an attendant may be required to accompany a total-care camper.**

Is the camper an independent adult requiring no supervision? Yes \_\_\_\_\_ No \_\_\_\_\_

In your opinion, under supervision, may the camper participate in:

Swimming Program Yes \_\_\_\_\_ No \_\_\_\_\_ Comments: \_\_\_\_\_  
Horseback Riding Program Yes \_\_\_\_\_ No \_\_\_\_\_ Comments: \_\_\_\_\_  
If Down Syndrome: Atlanto-A xial Subluxation? Yes \_\_\_\_\_ No \_\_\_\_\_  
Cervical X-Ray for Atlanto-A xial Subluxation? Positive \_\_\_\_\_ Negative \_\_\_\_\_ X-Ray Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Additional medical contraindications may apply to riding. Alternative horse-related activities will be offered.

Has the camper attended the Camp Beausite NW (formerly Northwest Kiwanis Camp) before? YES \_\_\_\_\_ NO \_\_\_\_\_

When? \_\_\_\_\_  
\_\_\_\_\_

Referred By: \_\_\_\_\_

List Interests, Hobbies, Activities, School Clubs, etc... \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Expectations/Goals for this camping experience: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the camper sunburn easily? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of person completing this application: \_\_\_\_\_

Relation to applicant \_\_\_\_\_

Camper's Full Name \_\_\_\_\_

I hereby give permission to the Camp Beausite NW medical personnel to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation in order to access medical care deemed necessary. In the event I cannot be reached in an emergency, I hereby give permission to the healthcare provider selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

**Over-the-counter medications**

Our Health Center stocks typical over-the-counter (OTC) medications such as Tylenol (acetaminophen), Advil (ibuprofen), Benadryl, Tums, Maalox, Kaopectate, Calamine lotion and hydrocortisone cream. These OTC medications are provided at no charge.

**However, it is in your camper's best interest to ensure that your physician completes the OTC medication authorization form that will allow the nursing staff to administer these medications to your camper. No medications (prescription, over-the-counter or herbal) will be dispensed to campers without the signature of a licensed practitioner.**

**Procedures regarding camper release:**

Campers will only be released to authorized persons during camp or at noon on the last day of the camp. Persons authorized to pick up the above named camper are:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

I understand that if the above named camper is not picked up by noon on the last day of camp, I may be subject to an extra charge.

The Camp Beausite NW Director will verify cause of absentees or 'no-shows' by contacting the above parent/guardian and or persons listed as emergency contacts on the camper application form.

I also agree to furnish CAMP Beausite NW with the Physical Examination Report, signed by a licensed physician, no later than **June 1<sup>st</sup>**. I understand that the camper will not be allowed to attend without this form. [A medical exam is required every year.]

This Health History is correct to the best of my knowledge, and the applicant described herein has permission to engage in all program activities except as noted. I also give permission to the medical personnel selected by the Director to order x-rays, routine tests and treatment for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the healthcare provider selected by the Director to hospitalize, secure proper treatment, order injections, anesthesia, or surgery for me/or my child as named above. This form may be photocopied for use out of camp.

**In consideration for acceptance, I hereby release and waive any claim, cause or action which may accrue against Camp Beausite NW, any employee thereof, or any other persons acting with their permission, arising from injury during his/her stay at Camp Beausite NW from said facility, or during any activity approved by any of said persons.**

**I hereby give permission to the Camp Beausite to take photographs, video or film of my camper and display on our website or use in our promotional materials. Yes \_\_\_ No \_\_\_**

Camper Name: \_\_\_\_\_ Camper Signature (18 or older): \_\_\_\_\_ Witness: \_\_\_\_\_

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