Camper Information

Basic Information

Name of camper: Sex: ☐ F ☐ M DOB:

Changed Information (since initial application): ☐ Home Address ☐ Medical Information

☐ School Services ☐ Therapy Services ☐ Challenging/Unsafe Behavior ☐ No Changes

Please provide more information about changes checked above:

Address:

City: State: Zip:

T-shirt size:

Physician: Phone:

Dentist/Orthodontist: Phone:

Medical insurance: ☐ Y ☐ N Insurance company:

Policy/ID #: Group #:

Parent 1 Name:

Daytime phone: Evening phone:

Parent 2 Name:

Daytime phone: Evening phone:

Emergency contact 1:

Relationship: Phone:

Emergency contact 2:

Relationship: Phone:

Dietary Needs

My camper has a life-threatening allergy: ☐ Y ☐ N

If yes, please give details:

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List food sensitivities:

Health Information

Immunization History

Please record the date (month/year) of basic immunizations and recent booster doses. The date of the most recent tetanus will be needed in the event of the injury.

Vaccines:	Date of immunization:
☐ Diphtheria/Pertussis (Whooping Cough) DPT/Tetanus ☐ Tetanus/Diphtheria TD ☐ Tetanus	
☐ Oral Polio (Sabin) TOPV	
☐ Measles (hard measles, red measles, Rubcola)	
☐ Mumps	
☐ Rubella (German measles, 3-day measles)	
☐ Other	

Conditions

☐ Frequent ear infections	Approximate dates:	Treatment:
☐ Heart defect/disease	Approximate dates:	Treatment:
☐ Seizures	Approximate dates:	Treatment:
☐ Diabetes	Approximate dates:	Treatment:
☐ Bleeding/clotting disorder	Approximate dates:	Treatment:
☐ Emotional/behavioral disorder	Approximate dates:	Treatment:
☐ Skin condition	Approximate dates:	Treatment:
☐ Asthma	Approximate dates:	Treatment:
☐ Arthritis	Approximate dates:	Treatment:
☐ ADHD	Approximate dates:	Treatment:
☐ Bedwetting	Approximate dates:	Treatment:
☐ Sleepwalking	Approximate dates:	Treatment:
☐ None of the above		
☐ Other:		

Allergies

☐ Hay fever	Typical reaction:	Treatment:
☐ Poison ivy	Typical reaction:	Treatment:
☐ Insect stings	Typical reaction:	Treatment:
☐ Penicillin	Typical reaction:	Treatment:
☐ Other drugs	Typical reaction:	Treatment:
☐ Food (kind)	Typical reaction:	Treatment:
☐ None		
☐ Other	Typical reaction:	Treatment:

Other diseases or details of above:

Operations or serious injuries (include dates):

Chronic or recurring illness/disability:

Any specific activities to be restricted:

Medical Consent

☐ My camper is sufficiently fit to participate in this program. I have completed the Health Information Form and disclosed health/medical information that is accurate, complete and true to the best of my knowledge.

☐ Should my camper become ill or injured, I give permission for the program facilitators to render first aid and to seek emergency medical or rescue services, as they see fit and at my cost.

☐ I hereby authorize the camp doctor, nurse, camp director or any representative of Avanti Camp Icaghowan to consent for examination and treatment of my minor child, providing such examination and treatment is made by a physician licensed under the provisions of the Medical Practice Act.

☐ I give consent for my child to have Tylenol as needed for headaches.

My child will need the following medication during camp, and I request that he/she be assisted by the designated camp personnel to follow our doctor's recommendation for its use:

Medication	Dosage	How often	Reason

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IMPORTANT: All medication must be in the original container prepared by a pharmacist or physician and clearly labeled with the camper's name and instructions for use. NO EXCEPTIONS.

☐ I consent that the above information is complete and accurate.

This authorization shall remain in effect until Saturday, July 3, 2015 (last day of camp.)

Occupational Therapy Information

This information will help us to better understand your child and plan the most appropriate treatment approaches that may help him/her be successful at Camp Avanti. If possible, this form is to be filled out jointly by parent and therapist.

Treatment History

Has your child received OT services at school in the past? ☐ Y ☐ N

Therapist name: _____

Describe: _____

Does your child receive OT services at school right now? ☐ Y ☐ N

Therapist name: _____

Describe: _____

Has your child received outpatient OT services (at a clinic) in the past? ☐ Y ☐ N

Therapist name: _____

Describe: _____

Does your child receive outpatient OT services right now? ☐ Y ☐ N

Therapist name: _____

Describe: _____

Has your child had an intensive brushing program (Wilbarger protocol)? ☐ Y ☐ N

What results/progress did you see? _____

Are you still using this technique? _____

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Has your child participated in any type of Sound Therapy (Auditory Training, AIT, Therapeutic Listening, SAMONAS, Tomatis method, etc.)? ☐ Y ☐ N

What results/progress did you see?

Are you still using this technique?

Has your child had an intensive oral motor program? ☐ Y ☐ N

What results/progress did you see?

Are you still using this technique?

Have you and your child been instructed in sensory diet activities (activities to help get the movement, tactile, oral, heavy work, sound and visual sensations needed to help your child be as organized, calm and focused as possible)? ☐ Y ☐ N

What results/progress did you see?

Are you still using this technique?

What specific strategies seem to help the most?

Arousal modulation	**Frequency**
Has difficulty getting to sleep	☐ Never ☐ Sometimes ☐ Often
Has difficulty sleeping through the night	☐ Never ☐ Sometimes ☐ Often
Has difficulty with bedwetting	☐ Never ☐ Sometimes ☐ Often
Has difficulty achieving situation-appropriate attention	☐ Never ☐ Sometimes ☐ Often
Has difficulty maintaining situation-appropriate attention	☐ Never ☐ Sometimes ☐ Often
Has difficulty shifting situation-appropriate attention	☐ Never ☐ Sometimes ☐ Often
Has difficulty adapting to changes in routine	☐ Never ☐ Sometimes ☐ Often

Make any statement that describes this child in more accurate terms than above:

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Responsivity	Frequency
Responds negatively to touch	☐ Never ☐ Sometimes ☐ Often
Has little or no response to touch	☐ Never ☐ Sometimes ☐ Often
Responds negatively to sounds	☐ Never ☐ Sometimes ☐ Often
Responds negatively to smells	☐ Never ☐ Sometimes ☐ Often
Becomes anxious or fearful when feet leave the ground	☐ Never ☐ Sometimes ☐ Often
Reacts positively to movement activities	☐ Never ☐ Sometimes ☐ Often

Make any statement that describes this child in more accurate terms than above:

Social/Emotional	Frequency
Engages easily in play with a small group of peers	☐ Never ☐ Sometimes ☐ Often
In a small group situation does your camper show significant inappropriate behavior?	☐ Silliness ☐ Isolation ☐ Arguing ☐ Controlling ☐ Other:
Engages with adults more easily than with peers	☐ Never ☐ Sometimes ☐ Often

Make any statement that describes this child in more accurate terms than above:

What are your camper's preferred leisure activities:

Communication: Does your camper have trouble MORE THAN HALF THE TIME…	Frequency
Using gestures or nonverbal communication	☐ Never ☐ Sometimes ☐ Often
Reading gestures or nonverbal cues	☐ Never ☐ Sometimes ☐ Often
Using verbal language to get physical needs met	☐ Never ☐ Sometimes ☐ Often
Using verbal language to get emotional needs met	☐ Never ☐ Sometimes ☐ Often
Using communication form to engage others socially	☐ Never ☐ Sometimes ☐ Often
Responding appropriately to communication from peers	☐ Never ☐ Sometimes ☐ Often
None of these	☐

Make any statement that describes this child in more accurate terms than above:

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Motor skills	Frequency
Has difficulty with balance on stairs, unstable surfaces and inclines	☐ Never ☐ Sometimes ☐ Often
Has difficulty with oral-motor skills	☐ Never ☐ Sometimes ☐ Often
Has difficulty with fine motor manipulation	☐ Never ☐ Sometimes ☐ Often

Make any statement that describes this child in more accurate terms than above:

Signature

By checking this box I attest that the completed information is accurate.

If at a later time you need to make changes to this information, please email those updates to info@campavanti.com.

Parent's signature: Date:

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