
Hershey Square #353, 152 Mae St, Hummelstown, PA 17036
(717)531-5338 (717)531-0761 (fax)

# CAMPER APPLICATION

## INSTRUCTIONS:

The application contains **9** sections. Please complete all sections. Because of State Regulations, all sections must be completed.

A photograph of the camper should be included. Please paste the photo directly onto the application.

A Pre-Camp Medical Evaluation, section 6, **MUST** be completed by the Physician, Specialist, Physician Assistant or Nurse Practitioner who usually cares for the camper. **The camper may not attend camp** if this portion of the application is not completed.

## Section One

**********Camper Identification**********

Camper's Full Name: _____
Last First Middle

Campers Address: _____
Apartment / Street Number

_____
City State County Zip Code

Age: _____ Birthdate: _____ Nickname: _____

Weight: _____ Shirt Size: _____ Sweat Pant Size: _____

Home Phone #_____ Cell Phone #_____

Alternate Phone # _____ Email:_____

Medication **ALLERGIES**:

_____

_____

_____

Food **ALLERGIES**:

_____

_____

_____

## Section Two

## **********Permission and Camper Release**********

State Law requires Campers who are less than 18 years old to have written Parental Consent to attend Camp. Further, in the interest of your child's safety, State Law requires that you specify to whom your child may be released (In addition to yourself) at the conclusion of Camp, ie. Grandparents, neighbor, or parents of another camper.

Please complete and sign each of the statements below.

_____ Has my permission to attend and participate in PA Vent Camp at Camp Victory in Millville, PA, June 25th – 29th, 2023

_____ _____

Parent / Legal guardian Signature Print Parent / Legal Guardian Name

_____ _____

Relationship to Camper Date

At the conclusion of Camp on Thursday, June 29th, the Camp Staff may release my child to myself and / or:

1. _____
2. _____
3. _____

_____ _____

Parent / Guardian Signature Print Parent / Legal Guardian Name

_____ _____

Relationship to Camper Date

## Section Three

## **********Consent to Photograph**********

The PA Vent Camp will photograph activities at camp to use for fundraising and publicity purposes. The following consent form allows PA Vent Camp and/ or affiliates to film for these reasons.

If you prefer that your and/ or child's photograph and or film appearance **NOT** be used, simply cross out this consent agreement.

### PA Vent Camp Consent Agreement

I hereby give my consent to the PA Vent Camp program and / or any other organization invited to camp to take and use my and / or my child's photograph, audiotape and/ or videotape recordings in any media for editorial, educational, promotional, advertising, or fundraising purposes.

_____ _____

Camper's Name Printed Date

_____ _____

Parent / Guardian Printed Parent / Guardian Signature

## Section Four

**********

Camp regulations require that **ALL MEDICATIONS** be administered by the Camp Health Staff. All prescription and non-prescription medications must be turned into the Health Staff when you arrive at Camp. Individuals may be allowed to keep inhalers after consultation with the Health Staff. **Please bring enough medications for the full week of camp plus <u>2 ADDITIONAL DOSES</u>** just in case.

Please complete the list below: (only those medications which your child will have at camp)

| Medication Name | Dose | Time Dose Given (please place Actual time you give the med) |
|---|---|---|
| Medication Name | Dose | Time Dose Given |
| Medication Name | Dose | Time Dose Given |
| Medication Name | Dose | Time Dose Given |
| Medication Name | Dose | Time Dose Given |
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| Medication Name | Dose | Time Dose Given |

Please send / bring all medications in their original containers.

| Medication Name | Dose | Time Dose Given |
|---|---|---|
| Medication Name | Dose | Time Dose Given |
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| Medication Name | Dose | Time Dose Given |
| Medication Name | Dose | Time Dose Given |

Please send / bring all medications in their original containers.

**Feeding Schedule:**

Diet Type: ☐ Regular Food ☐ Soft Food ☐Baby Food

☐ Formula _____ Formula Name

Tube Feeds: ☐NGT ☐NJT ☐GT ☐ JT

Formula Times: _____ Amount: _____

_____ Water: _____

_____ _____

_____ _____

Special Instructions – Please be specific:

**Elimination:**

Voiding Pattern: ☐ Voluntary ☐ Diapers

CIC: ☐ Frequency/Times: _____

Bowel Pattern: ☐ Voluntary ☐ Diapers

Bowel Program: _____

**Mobility:**

Ambulatory: ☐ Manual Wheelchair: ☐ Electric Wheelchair: ☐

Hospital Bed: ☐ Regular Bed: ☐

**Home Equipment (check if use)**

Apnea Monitor: ☐ Oximeter: ☐ Feeding Pump: ☐

Portable Suction: ☐ Air Compressor: ☐ Other: _____

Oxygen Home - Liquid: ☐ Concentrator: ☐

Oxygen Portable - Liquid: ☐ Cylinders: ☐

**Respiratory Status:**

| **Ventilator** | OR | **BiPAP/CPAP** |
|---|---|---|
| Model: _____ | | Model: _____ |
| Tidal Volume or Pressure Control: _____ | | IPAP: _____ |
| PEEP: _____ | | EPAP/CPAP: _____ |
| Rate: _____ | | Rate: _____ |
| Pressure Support: _____ | | Hi/Low Alarms: _____ |
| Pressure Limit: _____ | | FiO2: _____ |
| Hi/Low Alarms: _____ | | Other: _____ |
| FiO2: _____ | | |
| Other: _____ | | |

Time on Vent /BiPAP/CPAP: _____

Tracheostomy Brand: _____ Tracheostomy Size: _____

Cuff: Deflated: ☐ Inflated: ☐ Volume:_____

Speaking valve: ☐ Time used: _____ HME: ☐ Time used: _____

Coffalator: Settings:_____ Frequency:_____

Vest: Settings:_____ Frequency:_____

Suction: Cath Size:_____Depth:_____ Frequency:_____

**Community Care Providers:**

Home Care Case Manager: _____ Phone _____

Home Care Agency: _____ Phone _____

Medical Equipment: _____ Phone _____

Physician: _____ Phone _____

## Section Five

## **********Camper Health and Activity Profile**********

The health and well-being of the Campers and Staff is supervised by the Camp Health Staff of Doctors, Nurses and Respiratory Therapists. Please complete all requested information in the sections below. Please include any additional health concerns you may have that are not specifically requested in the space at the end of the section.

Does this camper suffer from any other recurrent illness? Please list.

Dates of most recent immunization:

DPT series (campers under age 10) _____

Td (campers over age 14) _____

Hepatitis B _____

Measles _____

Mumps _____

German Measles (Rubella) _____

Polio _____

H –influenza Type B (HIB _____

TB skin test (if completed) _____

COVID _____

The result of TB skin test was: POSITIVE ☐ NEGATIVE ☐

Is the camper prone to any of the following illnesses or conditions? Use the space below to explain any "YES" answers.

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Seizures / convulsions…… | | | Frequent Colds……... | | |
| Urinary Tract Infections……. | | | Wheezing…….. | | |
| Sinusitis…….. | | | Hayfever…….. | | |
| Severe Menstrual Cramps……. | | | Indigestion……... | | |
| Constipation…….. | | | Ear Infections……... | | |
| "Swimmer's Ear"…… | | | Bed Sores…… | | |
| Bee Sting Reactions…….. | | | Hepatitis Exposure…….. | | |

Other:

## Section Six

## **********Camper Medical Health Evaluation**********

This Section is to be completed by the physician, specialist, Physician Assistant or Nurse Practitioner who usually provides medical care to this camper. This evaluation must take place within 6 months to the beginning of Camp. (You may print this or submit physician's own form)

Camper's Name: _____

Vital Signs: Height:_____ Weight: _____

Pulse: _____ Resp. Rate: _____

Blood Pressure: _____

General Inspection: _____

_____

| | NORMAL | Findings Deviating from Normal |
|---|---|---|
| Head | | |
| Eyes /Vision | | |
| Nose | | |
| Mouth / Teeth | | |
| Ears / Hearing | | |
| Neck / Thyroid | | |
| Thorax / Lungs | | |
| Heart | | |
| Abdomen / Hernia | | |
| Skin | | |
| Lymphatic | | |
| Spine | | |
| Extremities | | |

Muscle Tone / control / contracture: _____

_____

Neurologic Exam: _____

_____

Suggested restriction on routine camp activities (if any): _____

_____

_____ _____

Signature of Licensed Evaluator Date of Exam

Section Seven
Emergency Contact Information
********** AND **********
Consent for Medical Treatment

Please Complete and Sign This Section

In Case of Emergency Contact:

**Name** _____

**Relation to Camper** _____

**City** _____

**Phone – Daytime** _____

**Phone – Evening** _____

**Phone – Alternate** _____

Alternate Emergency Contact:

**Name** _____

**Relation to Camper** _____

**City** _____

**Phone - Daytime** _____

**Phone - Evening** _____

**Phone - Alternate** _____

**Health Insurance Information**

**Primary Care Physician / Address** _____

_____

**Name of Insurance Company:** _____

**Company Address:** _____

**Policy Holder's Name:** _____

**Policy / Group ID #:** _____

**I,** _____ **hereby give my consent to have my child,**
**(**PRINT YOUR NAME**)**

_____ **may be treated by the Health Staff of the Pennsylvania Vent**
**(**Print Your Child's Name**)**
**Camp. Further, if the Camp Physician recommends transportation to another medical facility, I give my permission for that transportation and for the medical staff of that institution to evaluate and treat me / my child. I understand that the Camp Health Staff will contact the persons listed above should I / my child suffer any serious illness or injury.**

_____
DATE

_____
Parent / Guardian Signature

_____
Parent / Guardian Name – Printed

## Section Eight

**********Important**********

Please complete the following section for your child's camp partner to become more familiar with your child's needs and daily routine. Please provide detailed information

1. What is the cause of your child's need for respiratory assistance?

2. Tell us about your child's typical day. Please include waking time; morning routines; bathing routines; food preferences; usual activity; naps or rest periods; bedtime routines; and bedtime.

3. Describe your child's respiratory assistance. Please include: type of ventilator; use of oxygen; settings; type of airway (if any).

4. Describe airway management routines. Please include: suctioning; technique and frequency; size and type of suction catheter; trach. care; type of trach. and size, etc.

5. Describe any respiratory treatments. Please include: schedule and type of chest physiotherapy; nebulizer treatments; IPPB treatments; etc.

6. Describe reasons to vary from above routines.

7. Describe your child's diet. If on a special diet, please give specifics.

8. Are there any foods that should be limited or avoided?

9. Does your child need assistance with eating?

10. Describe your child's means of mobility. Include specifics regarding features, i.e how is the wheelchair controlled, attachments, etc.

11. Describe any regular maintenance (i.e. battery charging) that needs to be done to the wheelchair.

12. Describe your child's mobility routine, How many hours per day that he / she is in the chair, etc.

13. Does your child use splints, braces and / or custom seats? Please list routines for wearing / using these items.

14. Describe your child's therapy routine such as range of motion, stretching, etc.

15. List reasons to vary from this routine.

16. Describe your child's night-time needs. Please include type of bed; clothes; security items; special mattresses; positioning preferences; and other routines, i.e., snacks, night lights, prayers.

17. Describe your child's usual bowel and bladder habits. Please include use of diapers; catheterization; urinal; suppositories; etc.

18. Please describe any other treatments or routines not mentioned above.

19. How does your child communicate his / her needs?

20.How does your child interact with others?

21. What are your child's favorite hobbies or interests?

22. Does your child have any strong fears (darkness, water, thunder, bugs etc.)?

23. If your child becomes upset, how can we comfort him / her?

24. What is your child most looking forward to at camp?

25. Please include any other information that you feel would help your child's partner and health staff to better know your child.

## Section Nine

**********RELEASE**********

In consideration of PA Vent Camp permitting (my child _____ who is under 18 years old )(me) to attend PA Vent Camp at Camp Victory, I hereby, and for (my child's) (and my) heirs, executors, administrators, assigns, and all legal guardians, waive and release any and all rights and claims of any nature that (my child) (and I ) may have against PA Vent Camp, its officers, directors, counselors, volunteers, agents, and cooperating entities, and Camp Victory, their respective representatives, heirs, executors, administrators, successors, and assigns, for and against any and all injuries or damages of any nature, including death, which (my child) (and / or I) may suffer while taking part in PA Vent Camp or any activities connected with PA Vent Camp. I further understand that (my child) (and I) assume(s) all risks in participating in PA Vent Camp.

I further recognize that PA Vent Camp cannot be held responsible for loss of clothing or personal property while at camp. I will have all belongings plainly marked. In addition, I understand that some camp volunteers may be under the age of eighteen.

I consent to (my child's) (my) participation in camp activities that the camp staff determines to be appropriate.

_____ Print Name of Camper

_____ Print Name of Parents / Guardian

_____ Print Name of Parents / Guardian

_____ Signature of Camper (If camper over 18 years)

_____ Signature of Parents / Guardian (If camper under 18 years)

_____ Signature of Parents / Guardian (If camper under 18 years)

_____ Date

**ATTENTION PARENTS OR GUARDIANS**

Please list your telephone number and destination if you will be away while camp is in session.

_____

**PA Vent Camp 2024 ("Camp") COVID Vaccination Waiver**

All campers and volunteers are highly recommended to have received the primary series COVID vaccine and one booster. While highly recommended, the COVID vaccine is NOT required to attend camp. While we will be implementing safety precautions including PPE and testing of all persons entering the camp, we cannot guarantee that your child will not contract this or another virus while attending camp.

NAME (of child) _____

☐ Has received the COVID-19 Vaccine ☐ Declined to receive the COVID-19 vaccination.

By signing below, you acknowledge that your child is at risk of contracting COVID-19.

By signing below, you acknowledge that volunteers and other campers may not have received the COVID-19 vaccination and are at risk of spreading it to other persons.

NAME Of Parent/Guardian:_____

Signature of Parent/Guardian: _____

DATE: _____