

2011 - NEW ADVENTURE In Faith EVALUATION for Events at Camp Chippewa

Participant Health/Wellness Evaluation completed annually by Doctor, Parent/Guardian/Facility Case worker.

This form will need to be completed in full and return to our office ASAP: Camp Chippewa at 2577 Idaho RD Ottawa KS 66067 – voice 785-242-6797-fax 785-242-8525 –email office@campchippewa.org

EVENT Code/# You are registering for:

1) Choice: _____

2)Choice: _____

2011 season event codes are:

(#1104 June 6-8 ---#1110 June 13-15 ----#1124 July 7 ----#1125 July 8 ----#CH11NA5 May 21-22 ----
#CH11NA9 Sept. 17-18)

TODAYS DATE: _____

Parent/Guardian/Self if Own Guardian Section:

1. Participants Full Name _____
Mailing Address _____ Last Name _____ First Name _____
Telephone (____) _____
Birth date _____ Gender _____

2. Parent or other person to notify in case of an emergency: _____

Relationship to Participant: _____

Address _____ Telephone (____) _____ (day time)
Telephone (____) _____ (night time)

3. Insurance Company _____ Policy # _____

ALL SIGNATURES REQUIRED:

I, _____ am attending this event at my own will or with my parent/guardians permission, and in signing the consent below give permission for my Health Care Professional to complete the remainder of the document if needed. The signatures below agree to Medical Consent as written below:

My Own/PARENT’S/GUARDIAN’S CONSENT FOR MEDICAL TREATMENT AND MEDICATIONS

I hereby give my permission to the medical personnel selected by the New Adventure In Faith Event Coordinator/Facility Staff 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 for or arrange necessary related transportation for myself/my child. I also give my permission to release information on this form for the purpose of assisting with medical treatment.

In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the New Adventure In Faith Event Coordinator/Facility Staff to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied if necessary to complete treatment. I also understand the New Adventure In Faith Event Coordinator/Facility Staff will contact my emergency contact person(s) as soon as they are able in the event of any such emergency that concerns myself/my child/the person for which I am guardian of.

Signature of Participate _____ **Date** _____

Signature of Parent/Guardian _____ **Date** _____
(if participant is not own legal guardian)

DOCTOR and/or the Facility Health Care Director: (this section must be completed by Health Care Professionals/and If living at home completed by parent/guardian, (#4 - #18) and (#8 & #9 Must be checked and signed by participants doctor)

4. Title of Health Care Professional /

Doctor's Name _____

Address _____ Telephone (____) _____

5. What is the nature and degree of the camper's disability? (Describe fully, and note any Hearing, speech, sight, or disabilities that may limit physical activity in an outdoor setting - use separate paper if necessary)

6. Is the person stated above able to care for own personal hygiene, and self care needs (i.e. Eating, bathing, toileting, changing)? _____ Yes or _____ No.

Please complete specific areas this participant **will** or **will not** need assistance with:

Eating _____ Are special tools needed? _____

Bathing _____ If Yes... what help is needed _____

Shampooing _____ If Yes... what help is needed _____

Tooth brushing _____ If Yes... what help is needed _____

Combing and brushing hair _____ If Yes... what help is needed _____

Dressing and undressing _____ If Yes... what help is needed _____

Toilet needs _____ If Yes... what help is needed _____

Additional Comments for the area listed above: _____

7. Are all immunizations current for the person: _____ Yes, _____ No.

Date of LAST TETNUS SHOT - _____/_____/_____

8. **Doctor**, is this individual _____ capable of attending a one / two
(participants full name)

Overnight event away from healthcare professionals with only a Registered Nurse available to dispense medications:

Check one: _____ Yes / or _____ No (Dr. Please Initial to verify _____)

9. **Signature of Doctor:** _____ Date: _____

(Must have Doctors Signature and answer to questions #8 for participant to attend event)

10. Please list all medications that this person will need to take with them for 2 day 1 night weekend retreat they are wishing to attend. All medication and supplies should be brought in their original containers inside a Ziplock bag or other sealed container. The Retreat staff has the right to refuse participants at time of check in if all medications and supplies are not brought with the participant on that day; this includes syringes, or other applicators for administering med.

Medication _____	Dosage _____	Frequency _____	PRN _____
Medication _____	Dosage _____	Frequency _____	PRN _____
Medication _____	Dosage _____	Frequency _____	PRN _____
Medication _____	Dosage _____	Frequency _____	PRN _____
Medication _____	Dosage _____	Frequency _____	PRN _____
Medication _____	Dosage _____	Frequency _____	PRN _____
Medication _____	Dosage _____	Frequency _____	PRN _____
Medication _____	Dosage _____	Frequency _____	PRN _____
Medication _____	Dosage _____	Frequency _____	PRN _____
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Medication _____	Dosage _____	Frequency _____	PRN _____
Medication _____	Dosage _____	Frequency _____	PRN _____
Medication _____	Dosage _____	Frequency _____	PRN _____
Medication _____	Dosage _____	Frequency _____	PRN _____
Medication _____	Dosage _____	Frequency _____	PRN _____

If there is a change in medication between the time of registration and the time of arrival, send information with the participant on the day of check in.

11. Does this participant carry any communicable diseases that those working with this person should be made aware of?

Please list those below and what precautions should be taken: (these participants live in a dorm community living area during this event)

- 1) _____
What precautions to be taken: _____
- 2) _____
What precautions to be taken: _____
- 3) _____
What precautions to be taken: _____

12.. Please write in any appliances (e.i. leg braces, wheelchair, hand spacers, crutches, prosthesis, etc.) used by the camper, indicate if they are worn at night.

_____ Time worn _____
_____ Time worn _____
_____ Time worn _____

13. Do any of the following conditions apply, please specify in detail:

Allergies to DRUGS/Medications: _____

Allergies to FOODS/Animals/Materials: _____

Seizure problems: _____ Date of last: _____

Is this person on medication for Seizures? _____ If so, what _____.

Skin problems: _____

Bowel or Bladder problems: _____

Other Concerns:

14. Please explain any special Diet Needs (diabetic, pureed, etc.)

15. Socialization Development and needs: (check all that apply)

- _____ Shies away from strangers
- _____ Plays or relates cooperatively in a group community.
- _____ Refuses to obey those in authority
- _____ Deliberately abuses self _____ or others _____.
- _____ Prefers to be left alone _____ Prefers company of others _____.
- _____ Other behavior problems, anger _____, temper _____, over active _____, mood swings _____, Combativeness _____.
- _____ Becomes frustrated when _____
- _____ Handles frustration by _____
- _____ Responds to change in routine by _____
- _____ Responds to correction by _____
- _____ Discipline, what method works best to control unacceptable behavior? Explain in detail.

16. Supervision is Needed:

- _____ Must be watched constantly
 - _____ Plays (knowingly or unknowingly) with dangerous objects if not watched.
- Give specifics:

- _____ Wanders away while awake.
- _____ Wanders away in sleep within home.
- _____ Wanders away from home.
- _____ Takes supervision from those in authority
- _____ Takes things that do not belong to him/her knowing _____ it is wrong, not knowing it is wrong _____.

Please provide any additional Information that may help us with this persons Socialization/Supervision concerns as they participate in a community outdoor setting:

17. Has the participant been away from home overnight before? _____ How often _____?

18. Most Weekend Activities are revised to suit the need of the developmentally challenged according to the participants capabilities whenever possible, and all activities are supervised.

I, _____ give my permission for _____ to
(Parent/guardian/or facility Health care director in their absence) (Participants name)
participate in the activities I have marked yes or no below: (please write in Yes, or No to the following)
_____ Hiking _____ Lead Horseback ride _____ Archery _____ Fishing
_____ Wagon Ride _____ Crafts _____ Group Field Games (kickball, relays
etc.) _____ Bible Lesson/Worship _____ Swimming(Summer Sessions Only)

19. Participant please write a brief paragraph about yourself or have someone write it for you. Tell us something of your family and indicate your hobbies, likes and dislikes or anything to enable the Adult Leadership to know something about you before your arrival. (use additional paper if necessary)

20. Do you approve of photos, or statements made by/of the Participant to be used in promotional materials for the New Adventures in Faith programs of Camp Chippewa? Please check:
_____ yes _____ no.

21. Please offer any additional information to evaluate this Participants needs during their time at this event?

22. The Coordinator/Facility Staff of this event, or other authorized persons reserve the right to determine whether or not we are capable of accommodating a particular individual. Based on the physical/health issues described for this participant, and the accessibility of the facility reserved, and knowing those persons providing supervision/leadership for New Adventures in Faith program are provided for by Volunteer Staff, whom have no health care license/experience such as a nurse aid. We must receive this completed evaluation back to the address listed on the front as soon as possible to make this determination. Once received, and it's reviewed, by all persons necessary, a confirmation to the event will be sent by phone/letter. It may be necessary for the parent/guardian or facility of which this person resides at to send a caregiver to attend with them to provide the personalized care/transportation they may require while participating in the event.

23. **Signature of Facility Worker and title** if completing on behalf of the Parent / Guardian/ Resident:

The Facility STAFF Please Complete the following information

Your name and Title: _____

Facility Name & address: _____

Street _____ City _____ ZIP _____

Office phone: _____ Cell Phone: _____

Email address: _____

Day time Contact Person and Phone Number

If Transportation is from the Residential Facility this person resides at we need the following information:

Night time Contact Person and Phone Number (for emergency purposes)

