Duffield Camp and Retreat Center
Application & Registration Form

Date of Camp: July 10-July 16

Mail completed form to:
Duffield Camp Registrar
6 Lenox Ave.
Lancaster, NY 14086
Attn: Challenge Camp
716-683-0523

Camper Information:

Camper's Name: Last________________________ First______________ Nickname ___________

Camper's Address: ________________________ City _____________ State ____ Zip ________

Camper's Phone___________________________________ Age ____Sex____ Date of Birth ___/___/___

Primary Care Provider's Information:

Person filling out this form: __________________Relationship to Camper: _______ Phone: _______

Care Provider: ____________________________ Relationship to Camper: _______ Phone: _______

Provider's Address: ______________________________ City ___________ State ____ Zip _______

Best way to contact: (email, phone, mail) ____________ Email address_________________________

Emergency Contact Information:

1st contact name: _______________________ Phone ______________________ Relationship________

2nd contact name _______________________ Phone ______________________ Relationship _______

3rd contact name _______________________ Phone ______________________ Relationship _______

If the primary care provider plans to be away during the camp session, please indicate.
If so, the 2nd contact should be informed that he/she will be on 24 hour call.

Health Insurance Information:

Health Insurance Company: ___________________________ Name of Policy Holder: ______________

Policy Number: ______________ Group Number: __________ Medicaid Number __________________

Physician/Medical Information: **WE WILL ONLY ACCEPT DUFFIELD CAMP PHYSICAL FORMS**

Every camper must have a complete physical dated within one (1) year prior to the camp session. Please have your physician fill out **both** the physical and the over the counter medication form and **sign and date** the forms.

Any medication changes after the physical exam must be accompanied by a current written prescription from the camper's physician.

Name of Physician: ____

Physician's Address: ____

City: __________________________________ State: _____ Zip: _______ Phone: ___________

Most recent or pending date of physical: _____________

Has camper been hospitalized within the past three (3) years? ______

If yes, please explain in detail with dates:____

____

Ambulatory Abilities:

Does not apply ___ Walks with assistance ___ Slow walking ___

Unsteady walking ___ Difficulty on stairs ___ Braces ___

Other:____

Communication/Needs: ___Does not apply/ Communicates well and is easily understood
___Does not apply ___Limited, but communicates needs ___Impaired speech
___Uses gestures/signs ___Uses communication board ___Responds to directions
Other:____

Sleeping Needs/Information: ___Does not apply/Sleeps through the night
___Awakens during the night ___Walks in sleep ___Tends to wet the bed
Problems at bedtime (please describe): ____

Toileting Issues/Information: ___Does not apply/ Takes care of toileting needs by self
___Needs reminders during the day ___Needs reminders during the night
___Diapers at night
___Other: ____

Swimming Abilities: (Lifeguards are present at the pond when we swim.)
___ Enjoys water and can swim independently in deep water
___ Limited ability and should not go in the deep water ___Must wear a life jacket in the water
___ Other: ____

Assisted Daily living Skills:

	Independent	Verbal Prompts	Partial Assistance	Full Assistance
Showering				
Brushing Teeth				
Hair Care				
Shaving				
Toileting				
Dressing				
Menstruation				

Allergy Information: ___Does not apply (no allergies)

Allergy to:	Reaction:	Treatment:
Dust/Mold		
Insect Bites:		
Animals:		
Latex		
Sunscreen		
Food:		
Food:		
Medications:		
Medication:		

Other:____
(Must bring epi pen, bee sting kit, lactose free milk if appropriate.)

Food/Dietary Concerns:

Eating	**Independent**	**Needs Help**	**Dependent**	**Eating**	**Independent**	**Needs Help**	**Dependent**
Feeds self				Drinks			
Cuts food				Cleans self			
Pours drink				Other			

Has food allergies (please describe):____
Has GERD (gastroesophageal reflux) (explain) ______________________________________
Has diabetes / foods to avoid: ____
Is lactose intolerant/ foods to avoid: ____
Needs to be reminded to chew food: ____
Tends to overeat and needs reminders: ____
Other:

Interests/Behavioral Issues:
What does the camper like to do in spare time? _____________________________________
Does the camper work? (type of work?) ____
What does the camper like? ____
What does the camper dislike? ____
What kinds of things upset/frustrate the camper? ____________________________________
What strategies are used to manage behavior?_______________________________________
Circle any of the behaviors that apply:

Excitable	Passive	Friendly	Cooperative	Stubborn	Quiet
Active	Sensitive	Aggressive	Tantrums	Helpful	PICA
Inquisitive	Depressed	Sociable	Self-injurious	Bites	Hits
Non-compliant	Wanders	Runs away			

Uses inappropriate language　　　　Inappropriate sexual behaviors
Please explain any circled items and describe strategies used to manage behaviors.

____
Does camper smoke? ______ How often? ____________________(Please bring cigarettes for 8 days)
Should camper avoid exertion dues to heart or other health concerns? _________________________
Is camper's interaction with children appropriate? (If not, explain). ___________________________
Other important information: ____

____

Symptoms:(Circle any that apply frequently and how they are treated.)

Nausea		Nightmares	
Diarrhea		Dizziness	
Constipation		Earaches	
Stomach aches		Headaches	
Overfatigue		Specific Behaviors	

Present Medications: List all medications presently being used. Medications must accompany the camper. Medications must be in a prescription bottle and match this list as well as the doctor's list. If medication changes by the time of the camp session, a written prescription from the doctor must accompany the camper.

Medication	Dosage	Times Given	Reason

Permission Page: (*This must be signed for camper to attend camp.)*

The camper has my permission to attend Camp Duffield.

I have completed the preceding forms completely and to the best of my knowledge.

I attest to the fact that the camper is free of all communicable diseases prior to attending camp.

I give permission for camper's picture to be used in camp promotional materials.

I give permission for camper's picture to be taken and distributed to all campers and staff.

I agree to send the following:

~ $100.00 deposit with this application

~$400.00 balance no later than June 1st.

The full amount may be sent at any time prior to June 1st. If the camper has to cancel due to health issues prior to the camp session, the balance of $400 will be returned. If the camper is sent home during the camp session due to behavioral problems, there will be no refunds.

Signature: ____ Date: _____________

Print name: _____________________________ Relationship to Camper: ___________________

Medical Permission: *(This must be signed for camper to attend camp.)*

Please be prepared to fill out a form when registering camper on the first day of camp session indicating any illnesses, injuries, hospital visits, and medication changes that may have occurred after sending in this form. Changes must be accompanied by physician's note indicating that camper is able to participate in camp activity.

The nurses at camp may give camper routine medications and over the counter medications, monitor health status, and provide first aid and routine care. If there is any change in the camper's care or medical status, The caregiver will be notified.

If emergency treatment is necessary, I give permission for camper to be brought to the nearest emergency room available by ambulance or staff car for treatment. I authorize staff to release all records necessary for insurance purposes so that the insurance company can be billed for the visit, lab tests, and/or x-rays if necessary.

The camper will bring all necessary medications and supplies needed for seven (7) days. However, if camper needs any additional prescription medication, the caregiver will be notified and arrangements will be made.

In consideration of admission of camper to Camp Duffield, the undersigned hereby releases any and all claims for injuries suffered or sustained by the camper in going to or coming from camp, or while at camp and consents to hospital or medical care if needed.

Signature ____

Print Name ____Date __________________

Duffield Camp and Retreat Center
Physician's Report

Date of Camp: July: July 10- July 16

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6 Lenox Ave.
Lancaster, NY 14086
Attn: Challenge Camp
716-683-0523
Due: June 1st

CAMPER'S NAME ____________________________________

PHYSICAL

To be completed by camper's Medical Doctor
This form may be mailed separately from camper's application.
We will only accept this form for your child's physical.
Do not wait for this form to mail in your application.

INCLUDE CURRENT MARS

PHYSICIAN'S NAME ____
PHYSICIAN'S PHONE ____
PHYSICIAN'S ADDRESS ____

Your medical doctor must complete the next three (3) pages. The camper's exam must be dated no more than one (1) year from the camp session.

DIAGNOSIS	STATUS

ALLERGIES	REACTION/TREATMENT

IMMUNIZATION	DATE/RESULT
HAEMOPHILUS INFLUENZA TYPE B	
DATE OF LAST TETANUS SHOT	
TB TEST DATE	
MMR	
HEP B SERIES	
POLIO	
CHICKEN POX/VARICELLA	
DPT	
MENINGOCOCCAL VACCINATION	

Can this camper go swimming? _________ Restrictions ____
Does this camper have seizures? _______ Type ____________ Last Episode ___________ Restrictions ____________________

Other orders or recommendations (include skin care)
____
____

PHYSICIAN'S SIGNATURE _________________________________

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CAMPER'S NAME ____

DATE OF EXAM __________________ **HT** _____ **WT** _____ **HR** _____ **BP** _____**RR** _____

PHYSICAL EXAMINATION

SYSTEM	WITHIN NORMAL LIMITS	ABNORMAL	REASON
HEERT			
NECK			
LUNGS			
HEART			
ABDOMEN			
GENITALIA			
SPINE			
EXTREMITIES			
NEURO			
SKIN			

MEDICATIONS

Please list all medications the camper is currently taking. Any medication changes after exam date must be accompanied by a current written prescription from camper's physician.
Reasons must be given for each medication.

MEDICATION	DOSAGE	TIMES GIVEN	REASON	SPECIAL INSTRUCTIONS

PHYSICIAN'S SIGNATURE ______________________________ **EXAM DATE** ________________
PRINTED NAME ____ **LICENSE NUMBER** __________
ADDRESS ____ **PHONE** ____________________
CITY ____________________ **STATE** _______ **ZIP** _________ **FAX** _______________________

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CAMPER'S NAME ____

OVER THE COUNTER MEDICATION FORM

Your medical doctor must complete this form

I hereby authorize that the following medications may be given to the above named camper at Camp Duffield after nursing assessment.

Bactine (topical) for minor wound care, first aid as needed

Triple Antibiotic Ointment (topical) for wound healing

Tylenol (oral) as directed on bottle

Ibuprophen (oral) as directed on bottle

Chloraseptic Spray for sore throat as directed

Cough Drops for coughing, minor throat irritation as needed

Antacid Tablet (oral) for stomach discomfort

Benydryl (oral or topical) for swelling, hives, allergic reaction as directed on bottle

Loratidine/Claritin (oral) for seasonal allergies, as directed on bottle

Calamine Lotion or Cortaid (topical) for insect bites/bee stings

Visine/ Murine Plus Eye Drops (topical in eye) for minor eye irritation

Other (please describe) __________________________

PHYSICIAN CONSENT

Physician Signature ______________________________________ **Date** ______________________

Printed Name ____ **License Number** ______________

Address ____**Phone** _______________________

City ______________________________ **State** ________ **Zip** _______ **Fax** ______________________