

Shepherds Camp

serving adults with developmental disabilities

Dear Staff and Family of Campers,

Greetings from Arrowhead Bible Camp! I hope that this letter finds you well and warm in the midst of this winter season. This season is exciting for us here at camp as we host guest groups and prepare for summer 2013. This letter will inform and prepare you for the *Shepherds Camp* program this year.

Updates & New Information

* **Talk with our Counselors**- take some time to talk with our counselors at check in as they are excited to meet you and the campers; and will have some specific care needs they wish to discuss to ensure proper care during their stay.

* **Emergency Contact Info**- please make sure that at least one of the emergency contacts' information listed will be available and able to transport the camper if needed.

* **Health & Behavior Section**- these expanded sections of the registration and application forms help us to equip our staff to provide top care for campers

* **Check in Stations**- four stations will be implemented this summer for camper check in:

- 1) Camper Sign-in
- 2) Tuition Payment / Spending Money drop off
- 3) Medication drop off
- 4) Camper Bracelets

* **Spending Money**- campers may bring spending money for camp merchandise and the soda machine. Spending money will be logged and kept locked in the camp office for safekeeping.

I appreciate you taking the time to familiarize yourself with this information. If you have any questions about these specific areas or anything in regards to our *Shepherds Camp* program I encourage you to contact me. I look forward to this summer and seeing everyone back here at camp. In the meantime, please stay warm and healthy!

Sincerely,



Sadie L Engle
Program Manager
Arrowhead Bible Camp
Phone: 570-663-2419

Shepherds Camp

serving adults with developmental disabilities

Application & Registration Form

Camper _____ Age _____ M F DOB ___/___/___
Address _____ Phone () _____ - _____
City _____ State _____ Zip _____ County _____

Adult T- Shirt Size: (Circle One) XXL XL L M S Nickname _____

Has the camper attended Arrowhead before? Yes No Last year attended: 2012 _____

PLEASE NOTE: NEW CAMPERS NEED TO SCHEDULE MEETING WITH PROGRAM MANAGER

Care Provider _____
Home Phone () _____ - _____ Cell Phone () _____ - _____
Address _____ City _____ State _____ Zip _____
Care Provider E-mail address _____
Relationship to Camper: (FCP, parent, sibling, House Manager, etc.) _____

Please Check Program(s) Desired:

1 Week Programs

- Sunday June 9th - Friday June 14th, Check out @ 10:00 AM
 - Sunday June 16th - Friday June 21st, Check out @ 10:00 AM
- Cost per week \$425.00 Registration Fee: \$100.00 Due with Registration - Non-Refundable*
Balance: \$325.00 (includes Snack Shop, Camp Photo & T-shirt) Due May 22nd
Call for availability of other 1-week programs

2 Week Programs

- Sunday June 9th - Friday June 21st, Check out @ 10:00 AM
 - Sunday June 23rd - Friday July 5th, Check out @ 10:00 AM
 - Sunday July 28th - Friday August 9th, Check out @ 10:00 AM
- Total Cost: \$850.00 Registration Fee: \$100.00 Due with Registration - Non-Refundable*
Balance: \$750.00 (includes Snack Shop, Camp Photo & T-shirt) Due May 22nd

NEW! 1 to 1 Week

[open to campers who require individual care]

- Monday June 3rd, Check in @ 10:00 AM - Friday June 7th, Check @ 1:00 PM
 - Monday July 22nd, Check in @ 10:00 AM - Friday July 26th, Check @ 1:00 PM
- Total Cost: \$775.00 Registration Fee: \$100.00 Due with Registration - Non-Refundable*
Balance: \$675.00 (includes Snack Shop, Camp Photo & T-shirt) Due May 22nd

Make check or money order payable to: Arrowhead Bible Camp
Mail to: Shepherds Camp, Arrowhead Bible Camp, 122 Arrowhead Cottage Rd., Brackney, PA 18812
Questions? Call - (570) 663-2419 Fax- (570) 663-2903 www.shepherdscamp.org

Office Use Only

Rec'd: _____ Medical: _____ Amount: _____ Check #: _____ E: _____ C: _____

Camper Profile - please complete to the best of your knowledge

1. Sleeping Arrangements (Please check all that apply) *Shepherds Camp will do our best to honor these requests.

Does the camper require hourly night time bed checks? Yes No If yes, camper must be bunked in the dorms.

Camper requests to stay in: Cabin Dorm (*dorms are **upstairs** in the main building*)

Camper requests to be bunked with _____

2. Toileting and Overnight Care (Please check all that apply)

Wets Bed: Never Occasionally Frequently

Please explain how bed-wetting is handled: _____

- Sleeps through the night Has Nightmares Needs to be awakened to use the toilet
 Uses Diapers/Depends If yes: At night only Occasionally Always
 Uses Portable Urinal at Night

Other information regarding toileting needs: _____

3. Mobility (Please check all that apply)

- Normal Walking Cane(s) Braces When are they worn? _____
 Slow Walking Crutches Other information concerning mobility: _____
 Unsteady Walking Wheelchair _____
 No Walking Walker _____

4. Personal Care/Hygiene: (Please check all that apply)

	Independent	Needs Help	Total Care	Comments
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brushing Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Using Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Washing Hands and Face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tying Shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Menstruation (women only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does the individual wear glasses? Yes No

Does the individual wear Dentures? Yes No

Please provide any other necessary information: _____

5. Eating (Please check all that apply) - Please note Shepherds Camp is unable to prepare special diets.

- Eats independently Describe camper's appetite: poor normal overeats
 Needs help eating Has trouble swallowing: solid foods liquids
 Needs food cut up Needs to eat food that is: chopped pureed
 Uses straw for liquids Needs to be fed: some foods all foods

Please describe any special/adaptive eating equipment (provided by care provider): _____

Please explain any other information regarding eating habits: _____

Is the individual diabetic? No Yes; if yes does he/she take insulin shots/medication diet-controlled

Please specify diabetic diet restrictions/modifications: _____

Please Note: Camp staff will make every effort to monitor the amount of food/liquid served to the camper.

6. Camper Health (Please check all that apply - Double check if applies within the past year)

- Frequent Ear Infections Frequent Sore Throats Frequent UTI Frequent Diarrhea Frequent Constipation
 Seizures Heart Defect/Disease Hypertension Bleeding/Clotting Disorders Psychiatric Treatment Headaches
 Mononucleosis Asthma Other (Specify) _____

Allergies- Hay fever Insect Stings Nuts Penicillin Sulfa Other Drugs _____

Other (Specify) _____

Diseases- Chicken Pox Measles German Measles Mumps Rubella Hep A Hep B Hep C

Rheumatic Fever Other (Specify) _____

Camper Profile – Continued

7. Communication (Please check all that apply)

- Normal Speech Impaired Speech Hearing Aids Sign Language No Speech Communication Board/Book

8. Personality and Behavior (Please check all that apply)

(Please feel free to attach any additional paperwork to help serve camper's behavioral needs- ISP, etc)

The Shepherds Camp Program accepts teenagers and adults with developmental disabilities who are without aggressive behavior, who can communicate their needs, who are ambulatory and independent in eating and toileting. Shepherds Camp is unable to accept campers limited to wheelchairs. The camper should be able to participate in the program. Rules for acceptance and participation in the program are the same for everyone without regard to race, color, sex, age, or national origins.

- | | | | | | | |
|--------------------------------------|------------------------------------|---|---|----------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Active | <input type="checkbox"/> Excitable | <input type="checkbox"/> Behaves | <input type="checkbox"/> Listens | <input type="checkbox"/> Helpful | <input type="checkbox"/> Participates | <input type="checkbox"/> Cooperative |
| <input type="checkbox"/> Inquisitive | <input type="checkbox"/> Passive | <input type="checkbox"/> Quiet | <input type="checkbox"/> Follows Instructions | | <input type="checkbox"/> Tantrums | <input type="checkbox"/> Refuses |
| <input type="checkbox"/> Stubborn | <input type="checkbox"/> PICA | <input type="checkbox"/> In Need of Constant Watching | | | | |

Please describe any fears the individual may have? _____

Please describe camper personality on a typical day: _____

What assistance/prompts do you give the camper on a daily/weekly basis: _____

Is camper prone to wander? Yes No Please detail recommendations for dealing with this in camp environment: _____

Does camper have a history of inappropriate behavior to the opposite sex (peers & Staff)? Please explain: _____

How does camper act when upset or angry? How frequent does this occur: _____

Additional comments that would be helpful for staff to know. **Remember, even the camper has attended before, his/her counselor for the session may be new and unfamiliar with the camper. It is best to be thorough so staff can better understand the camper's unique needs** (attaché additional pages if necessary): _____

Is the camper attending school? Yes No If yes, grade level and school _____

Is the camper employed? Yes No If yes, type/location of employment _____

9. Program Information

What activities does the camper enjoy? _____

What activities does the camper NOT enjoy? _____

Does the camper sunburn easily? Yes No If yes, please list restrictions: _____

Is the camper allergic to bee stings or other insect bites? Yes No If yes, please describe the reaction and how it should be treated: _____

Should the camper avoid exertion due to heart or other health concerns? _____

Please describe any other allergies or health concerns that may hinder the camper's participation: _____

10. Swimming: (please check all that apply) Note: A certified lifeguard is on duty at all times.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Enjoys water | <input type="checkbox"/> Fears water | <input type="checkbox"/> Must wear earplugs | <input type="checkbox"/> Seizure prone in water |
| <input type="checkbox"/> Swims independently | <input type="checkbox"/> Cannot swim | <input type="checkbox"/> Needs 1:1 supervision | |
| <input type="checkbox"/> May ride in Paddle Boats (assisted by a staff person in the boat and wearing a life jacket at all times) | | | |
| <input type="checkbox"/> Shallow End swimming (0-4 feet deep) | <input type="checkbox"/> Must wear life jacket in shallow end | | |
| <input type="checkbox"/> Deep End swimming (over 6 feet deep) | <input type="checkbox"/> Must wear life jacket in deep end | | |

Spiritual Programming: Shepherds camp is an interdenominational Christian ministry.

Camper's religious preference/denomination: _____

Activity Restrictions

Please review the following camp activities and determine whether the camper may participate. Please contact the camp office with any questions. All activities are closely supervised and modified to fit the camper's individual ability level.

Adaptive Archery	Yes	()	No	()	Basketball	Yes	()	No	()
Volleyball	Yes	()	No	()	Nature Walks/Hikes	Yes	()	No	()
Kickball	Yes	()	No	()	Fishing	Yes	()	No	()
Hay Ride	Yes	()	No	()	Bowling	Yes	()	No	()
Mini Golf	Yes	()	No	()	Bocce Ball	Yes	()	No	()

11. Medical Information

Please enclose a completed medical/physical form with the Application/Registration Form. If you are unable to do so please state why and give date that the physical is scheduled.

Reason: _____ Date Scheduled: _____

12. EMERGENCY CONTACT INFORMATION- Campers will not be admitted without completed emergency contact ALL INFORMATION BELOW NEEDS TO BE UPDATED AND RELEVANT AT CHECK IN

Is the primary care provider planning to be away during the camp sessions?

No, the primary care provider will be the contact person during the camp session.

Yes, the primary care provider will be away during the camp session and has informed the 24 hour contact person that they will be on call.

Emergency Contact Person - 24 hour coverage - other than primary care provider which will be contacted first: In the event that the camper needs picked up early from camp please list appropriate person(s) contact info below.

Name: _____ Relationship to Camper: _____ Phone: (____) ____ - _____

Social Worker/Case Worker: _____ Phone: (____) ____ - _____

Other names/numbers: _____

13. Permission/Medical Release/Authorization for Treatment

The following must be signed by custodial parent/guardian, care provider, or camper if self guardian.

A. The camper listed above has my permission to attend and participate in the above named camp activity.

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

C. I grant permission for the Camp Nurse to treat minor illnesses and dispense campers' medication. I understand all medication must be given to and dispensed by the Camp Nurse.

D. I hereby give my permission to the medical personnel selected by the camp program manager to order x-rays, routine tests, treatment, and necessary transportation for the above named individual. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the individual as named above.

E. I attest to the fact that the above named individual is free of any communicable disease prior to attending camp.

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

Signature: _____

Please print name: _____

Date: _____

After review of the preceding information, the camp program manager will make a decision regarding acceptance into the camp program. **All necessary paperwork must be completed, signed, and submitted by May 22nd.** If the camper is accepted, you will receive a confirmation letter, medicine administration form, and list of what to bring to camp. The primary care provider will be contacted if the camp program manager has any concerns regarding acceptance. The registration fee will be refunded if the camper is denied acceptance to the program.

Shepherds Camp

FAMILY/GUARDIAN/CARE PROVIDER

2013 Medical Form

Please Print

Camper _____ Age _____ M F DOB ___/___/___
Phone () _____ - _____

Parent/ Guardian / Care Provider Name(s) _____
Insurance _____ Policy # _____

Your Medicare/Medicaid coverage or personal/family insurance would apply to all claims while at camp.
However, the camp does provide Excess Medical Expense coverage.

Physician's Name _____ Phone () _____ - _____

List all physical disabilities, special instructions, recent injuries or sickness (give diagnosis)

Symptoms: Please check which problem areas experienced frequently by the camper and how you treat these at home. (Example: Diarrhea give Pepto Bismol)

Symptom

Remedies

- | | |
|--|-------|
| <input type="checkbox"/> Nausea | _____ |
| <input type="checkbox"/> Nightmares | _____ |
| <input type="checkbox"/> Diarrhea | _____ |
| <input type="checkbox"/> Stomach-aches | _____ |
| <input type="checkbox"/> Dizziness | _____ |
| <input type="checkbox"/> Headaches | _____ |
| <input type="checkbox"/> Over fatigue | _____ |
| <input type="checkbox"/> Earaches | _____ |
| <input type="checkbox"/> Constipation | _____ |

Allergies

- No Known Allergies
- Foods _____
- Penicillin
- Other drug allergies _____
- Hay fever
- Poison ivy
- Insect bites _____
- Reaction: _____
(if bee sting, then the person is responsible to bring an appropriate sting kit.)
- Other allergies _____

Medication:

Yes, the camper is regularly on medication. **Please contact your camper's doctor regarding any medications, topical ointments, etc. that could be put on hold while at camp.** A medicine administration form will be sent with the confirmation letter which must be completed and submitted to camp by June 1st, 2013.

Seizures:

Yes, the camper experiences seizures. Campers prone to seizures will be accompanied in the lake with an Arrowhead Bible Camp Staff member. If there are any other restrictions due to this occurrence, please list Date of last seizure _____ Frequency of seizures _____

Signature of the Parent/ Guardian/ Care Provider

Date

Mail to: Shepherds Camp, Arrowhead Bible Camp, 122 Arrowhead Cottage Rd., Brackney, PA 18812
Please call Arrowhead Bible Camp with any questions (570) 663-2419
Fax: (570) 663-2903

Side 1

Shepherds Camp

ATTENDING PHYSICIAN

2013 Medical Form

Please Print

Or a current (**within 1 year of camp date**) health physical may be attached.
Reverse side must be completed by parent/care provider.

Camper's Name _____

Physician's Name _____ Phone () _____ - _____

Address _____ State _____ Zip _____

Hospital associated with: _____

General Physical Condition

Height _____ Weight _____ BP _____ Eyes _____ Ears _____ Lungs _____

Skin: Clear _____ Dermatitis _____ Eczema _____ Infections _____

Date of last Tetanus shot _____ Is this camper subject to seizures? No Yes

Should the camper be restricted from any camp activities? No Yes, _____

Medication

Please list the medications prescribed by you (**or attach current medication list**). If there are any medications (topical ointments, etc.) that could be put on hold while at camp please attach appropriate documentation and inform the parent or care provider.

Medication _____ Qty _____ Frequency _____

Medication _____ Qty _____ Frequency _____

Medication _____ Qty _____ Frequency _____

Medication _____ Qty _____ Frequency _____

Mental Evaluation

Diagnosis _____

Further Comments: _____

Physician's Signature

Date

Side 2

Shepherds Camp

Consent for Non-Prescription Medications

2013- for use during camp stay only

Camper Name: _____

This is a list of commonly used over the counter medications that are stocked at camp. Please check each medication that the camper may receive while at camp. The camp nurse dispenses all medication and notes them on the camper's camp medication sheet.

****ALL CAMPERS NEED TO HAVE A Consent for Non-Prescription Medications SUBMITTED TO ATTEND ENROLLED SESSION OF SHEPHERDS CAMP****

_____ Tylenol (acetaminophen): 2 tablets (325 mg) by mouth for headache or temperature of 101F or over, or for c/o minor pain, every 4 hours as needed (PRN). Maximum Daily Dose (MDD) 12 tabs per day. Not to exceed 2 days

_____ Ibuprofen: 1 tablet (200mg) by mouth every 4 hours for muscle aches (given with food) not to give simultaneously with other analgesics (i.e.: Tylenol or Aspirin). Not to exceed 2 days. Maximum Daily Dose 6 tabs.

_____ Bacitracin Ointment: Apply a small amount to affected area for minor skin abrasions to open sores BID as needed. Not to exceed 2 days. Maximum Daily Dose 2 times per day.

_____ Calamine Lotions: Moisten cotton or soft cloth with lotion to apply to affected areas to alleviate itching, to rash area, or bug bites TID as needed. Not to exceed 2 days. Maximum Daily Dose 3 times per day.

_____ Robitussin: Administer 2 tsp. every 4 hours as needed for cough. Not to exceed 2 days. Maximum Daily Dose 12 tsp. per day.

_____ Maalox/Mylanta: Administer 2 tsp. by mouth as needed between meals, at HS for indigestion. Not to exceed 2 days. Maximum Daily Dose 4-8 tsp. per day.

_____ Pepto-Bismol (bismuth subsalicylate): 2 Tbsp. by mouth every hours as needed for upset stomach and/or diarrhea. Not to exceed 8 doses in 24 hours, or use until diarrhea stops but not more than 2 days.

_____ Cough drops: for minor throat irritation/sore throat. 1 drop every 2 hours not to exceed 6 per day over 2 days.

_____ Benadryl (Diphenhydramine HCl): 2 tablets (50mg) every 4 to 6 hours for runny nose, sneezing, itchy, watery eyes, itching nose or throat. Not to exceed 6 doses in 24 hours. Not to exceed 2 days.

_____ Milk of Magnesium: for constipation (no bowel movement after 3 days) take 2-4 Tbsp. followed by large glass of water. If no bowel movement within 24 hours, camp nurse or program staff will notify camper emergency contact.

Parent/Care Provider Signature: _____ Date: _____

Physician Signature (if required*): _____

*only required if required by your agency/home/department