



2011 CAMPER APPLICATION

PLEASE PRINT CLEARLY

Camper's Name: \_\_\_\_\_ Gender: \_\_\_\_\_

School Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Birth Date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Age at Time of Attendance: \_\_\_\_\_

Street: \_\_\_\_\_ Apt./P.O.Box # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Mother/Female Guardian**

Full Name: \_\_\_\_\_

Address (If different than child): \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Camper; Please circle all that apply: Natural child      Relative      Legal Guardian

**Father/Male Guardian**

Full Name: \_\_\_\_\_

Address (If different than child): \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Camper; Please circle all that apply: Natural child;      Relative;      Legal Guardian

List other siblings/relatives attending camp at the same time: \_\_\_\_\_

\_\_\_\_\_

**Referring Agency:** \_\_\_\_\_

If D.S.S., please specify which office: \_\_\_\_\_

Agency contact person: \_\_\_\_\_ Agency Telephone: \_\_\_\_\_

## Camp Wee-Kan-Tu

### Method of Payment

\_\_\_\_ Check payable to EF MA, RI, NH, ME; mail to 540 Gallivan Blvd. Boston, MA 02124

\_\_\_\_ Credit Card (MasterCard or VISA) you may call 1-888-576-9996 to pay by phone or mail to office

Card # \_\_\_\_\_ Exp. Date: \_\_\_\_\_

I give permission for my child to attend camp and to participate in all programs, which may include activities off the camp premises. I have studied the fees and schedules and understand the contents thereof.

I agree to pay the balance of the fee (\$375.00) at least 30 days before camp session begins; knowing that failure to do so may automatically cancel this application. NO refund on the balance of fees will be granted except in the case of verified illness.

In order to provide the highest level of childcare and medical treatment, I give permission to staff of Camp Wee-Kan-Tu to share information concerning my child's seizure activity and/or other health issues with each other during his/her stay at camp.

I agree that photos, videos and other promotional media maybe taken of my child, and may be used for future educational, promotional or fundraising materials. I also consent to the use of child's photograph in all media, including the Epilepsy Foundation MA, RI, NH & ME and Camp Wee-Kan-Tu websites, to depict and/or identify him/her as a child with epilepsy. I also agree that Camp Wee-Kan-Tu will observe all reasonable precautions for the care and protection of my child.

By signing this application, I hereby release and hold harmless the camp, and its directors, officers, employees, agents and representatives from any and all damages, claims, injuries and liabilities, which may arise out of my child's attendance at Camp Wee-Kan-Tu and out of his/her participation in any activities while in attendance.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

This application is subject to prior registrations. To hold a space for the camper, please send a \$50.00 deposit for the camp using one of the above options. This is for administrative and processing expenses and is not refundable or transferable under any circumstances. This is in addition to the \$375.00 Camp fee.

# Camp Wee-Kan-Tu

## FINANCIAL ASSISTANCE APPLICATION

How to apply:

- Complete this financial assistance application
- Attach a copy of your most recent Income Tax Form (Top 2 pages only with gross adjusted income)
- Recent Pay stub/Income verification
- Complete ALL the Camp Admissions Application

Financial assistance will be reviewed in the spring of each camp year. Allocation of funds will be awarded based on availability of funding from Camp Wee-Kan-Tu. Once assistance is awarded, you will be notified via phone or email and your camper will be registered. Funds are based on donations and private funding; we appreciate any amount you are able to pay towards your child's camp experience. A camper cannot be registered until financial assistance is awarded or full payment is received if the assistance is not awarded.

PLEASE NOTE: THE ACTUAL COST PER CHILD TO ATTEND CAMP FOR 5 DAYS IS \$1,200.00. \$825.00 OF THIS IS COVERED BY FUNDS RAISED BY THE EPILEPSY FOUNDATION MA, RI, NH & ME, LEAVING A REMAINING BALANCE OF \$375.00 TO BE COVERED BY THE FAMILY OR FINANCIAL ASSISTANCE.

Name of Child: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

City/ State/Zip Code: \_\_\_\_\_

Has your child ever attended overnight camp before? \_\_\_\_\_ If yes, where? \_\_\_\_\_

Does your family receive financial assistance from any other agency? \_\_\_\_\_

If yes, please explain:

How much are you willing and able to pay towards your child's camp experience?

If you are not awarded financial assistance or only receive partial assistance, do you want your child registered for camp with the understanding that the full (or remaining) balance of \$375.00 will be paid by you no later than 30 days prior to the beginning of camp?

**YES**

**NO**

To the best of my knowledge all information provided is true and correct.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Email \_\_\_\_\_ Phone/Daytime: \_\_\_\_\_

## **Camp Wee-Kan-Tu**

Please explain any special circumstances to be taken in consideration for this financial assistance. Use additional paper if necessary.

**Camp Wee-Kan-Tu**

**CAMPER RELEASE FORM**

Date: \_\_\_\_\_

I, (parent or guardian name): \_\_\_\_\_ authorize

CAMP WEE-KAN-TU to release my child \_\_\_\_\_ to the designated individual(s) below in the event that I am unable to pick my child up at the close of camp.

1. Designated Individual Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

2. Designated Individual Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

3. Designated Individual Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_

**Camp Wee-Kan-Tu**

**Primary Hospital/Physician Information Form**

**Please Print Clearly**

**Camper Name:** \_\_\_\_\_

**Primary Hospital:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Hospital Phone Number:** \_\_\_\_\_

**Primary Physician/Pediatrician Name:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Primary Physician/Pediatrician Phone Number:** \_\_\_\_\_

**Neurologist Name:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Hospital Affiliation:** \_\_\_\_\_

**Neurologist's Phone Number:** \_\_\_\_\_

**Dentist/Orthodontist Name:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Dentist/Orthodontist Phone Number:** \_\_\_\_\_

I give the Health Care Team at Camp Wee-Kan-Tu permission to contact my child's health care provider if necessary.

**Parent Signature:** \_\_\_\_\_

**Print Parent's name:** \_\_\_\_\_

**HEALTH HISTORY AND EXAMINATION FOR CHILDREN, YOUTH AND ADULTS ATTENDING CAMP**

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. This form, except for the "Health Recommendations of Licensed Medical Personnel" is to be filled in by the parent/guardian of minors or by adult applicants.

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at Camp \_\_\_\_\_

**EMERGENCY CONTACT(S) if parents are not available**

1. Name \_\_\_\_\_

Relationship to child \_\_\_\_\_

Address \_\_\_\_\_

Telephone HOME \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

2. Name \_\_\_\_\_

Relationship to child \_\_\_\_\_

Address \_\_\_\_\_

Telephone HOME \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

**INSURANCE INFORMATION**

Is the participant covered by medical/hospital insurance?

If yes, please give CARRIER/PLAN NAME \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_

CARRIER ADDRESS \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_

SS# OR INSURANCE ID # \_\_\_\_\_

**\*IMPORTANT – THIS BOX MUST BE COMPLETED FOR ATTENDANCE TO CAMP\***

Parent/Guardian Authorizations: this health history is correct and complete to the best of my knowledge. The person described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give my permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips outside the camp.

Signature of parent/guardian or adult camper/staffer \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of CAMPER or STAFFER \_\_\_\_\_

\*If for religious reasons, you cannot sign this form, contact the Epilepsy Foundation MA, RI, NH, & ME for a legal waiver, which must be signed for attendance\*

**HEALTH HISTORY**

The parent/guardian or adult staff member must fill in the following information. The intent of this information is to provide camp health care personnel the background to assure appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information for your safety.

**ALLERGIES**

Medication

Describe reaction and management

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Food

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other allergies (insect bites, hay fever, environmental allergies)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Latex

\_\_\_\_\_

**Dietary information: (for personal/religious reasons, not allergies)**

Does not eat:

Red Meat  Eggs  Dairy Products  Pork  Seafood  Poultry

**KETOGENIC DIET**

Will the camper be following the Ketogenic Diet at the time of camp?

If yes, please discuss this with the nurse prior to camp and review specifics of your child's Ketogenic Diet to include foods to avoid at camp and specific food/meals that you will provide. We will work with you and notify the counselors/kitchen staff to best support this part of your child's epilepsy care. Please include any written information from your child's neurologist/nutritionist that may be helpful while at camp to best assure that we follow the diet correctly.

**GENERAL HEALTH QUESTIONS**

	<b>General Health Questions</b>	<b>Yes</b>	<b>No</b>
1.	Recent injury, illness or infectious disease		
2.	Chronic or recurring illness or condition		
3.	Hospitalizations		
4.	Surgery List all below including seizure surgeries, Vagal Nerve Stimulator, other surgeries		
5.	Frequent headaches		
6.	Head injury with/without loss of consciousness		
7.	Frequent ear infections		
8.	Dizziness and/or fainting associated with exercise		
9.	Chest pain during or after exercise		
10.	High blood pressure		
11.	Heart murmur/irregular heartbeat		
12.	Recurrent back pain/disc disease		
13.	Joint disease/arthritis		
14.	Skin conditions (e.g. itching, rash, acne)		
15.	Diabetes		
16.	Asthma		
17.	Mononucleosis in the past 12 months		
18.	Diarrhea/constipation chronically		
19.	Abnormal menstrual history		
20.	History of bed-wetting		
21.	Eating disorder		
22.	Hydrocephalus/shunt placement		
23.	Emotional difficulties/Professional counseling		

Please explain any “yes” answers, noting the **number** next to the diagnosis.

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When did your child first have a seizure? Was the seizure(s) related to brain surgery, head trauma, brain infection, febrile seizures, or unknown cause? Please describe the progression or regression of your child's epilepsy. \_\_\_\_\_

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Which of the following illnesses has your child had?

- Measles       German measles       Mumps       Chicken Pox   
 Hepatitis A       Hepatitis B       Hepatitis C

**Camp Wee-Kan-Tu**  
**TB Mantoux Test**

Camper's name \_\_\_\_\_

Date of last test \_\_\_\_\_ Result Positive  Negative

Vaccine	Original Series Date	Current Booster Date
DTP		
TD		
Tetanus		
Inactivated Polio virus		
Measles		
Mumps		
Rubella		
Haemophilus		
Hepatitis A		
Hepatitis B		
Varicella (Chicken Pox)		
Meningococcal		
Human Papilloma virus		

**MEDICATION LIST**

Please list **ALL** medications including over-the-counter or nonprescription drugs taken routinely. **We request that you bring enough medication for 7 days.** Keep prescription drugs in the original packaging/bottle that identifies the prescribing physician, your child's name, dosage, frequency of administration and pharmacy phone number. Keep over the counter medicines in the original container with your child's name, dosage and frequency of administration clearly marked on the package/bottle. The nurse will fill a SEVEN day medication box with you upon check-in. We will return ALL unused medications at the completion of camp. In addition, if your child uses any medications "as needed" (prn) or as unscheduled, please include these with the medications brought to camp. (e.g. Diastat/Ativan/cough syrups/inhalers)

**IMPORTANT MEDICATION INFORMATION**

We give medications at breakfast (8:00-9:00 a.m.), lunch (12:30-1:30 p.m.), mid-afternoon (2:00-3:00 p.m.), dinner (5:30-6:30 p.m.) and bedtime (8:00-9:00 p.m.). We respect those who require food with medicines and those who may need to take the medication prior to eating. We try to accommodate both groups. If you have specific concerns about your child's schedule, please discuss them with Sara Dagen prior to camp.

**No medications taken at all \_\_\_\_\_ . Check on line if this is true.**

1. Medication: \_\_\_\_\_

Dosage (does this vary throughout the day? How many pills equal that dosage?) \_\_\_\_\_

Specific times taken each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_

2. Medication: \_\_\_\_\_

Dosage (does this vary throughout the day? How many pills equal that dosage?) \_\_\_\_\_

Specific times taken each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_

3. Medication: \_\_\_\_\_

Dosage (does this vary throughout the day? How many pills equal that dosage?) \_\_\_\_\_

Specific times taken each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_

4. Medication: \_\_\_\_\_

Dosage (does this vary throughout the day? How many pills equal that dosage?) \_\_\_\_\_

Specific times taken each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_

5. Medication: \_\_\_\_\_

Dosage (does this vary throughout the day? How many pills equal that dosage?) \_\_\_\_\_

Specific times taken each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_

6. Medication: \_\_\_\_\_

Dosage (does this vary throughout the day? How many pills equal that dosage?) \_\_\_\_\_

Specific times taken each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_

7. Medication: \_\_\_\_\_

Dosage (does this vary throughout the day? How many pills equal that dosage?) \_\_\_\_\_

Specific times taken each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_

8. Medication: \_\_\_\_\_

Dosage (does this vary throughout the day? How many pills equal that dosage?) \_\_\_\_\_

Specific times taken each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_

9. Medication: \_\_\_\_\_

Dosage (does this vary throughout the day? How many pills equal that dosage?) \_\_\_\_\_

Specific times taken each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_

10. Medication: \_\_\_\_\_

Dosage (does this vary throughout the day? How many pills equal that dosage?) \_\_\_\_\_

Specific times taken each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_

11. Medication: \_\_\_\_\_

Dosage (does this vary throughout the day? How many pills equal that dosage?) \_\_\_\_\_

Specific times taken each day \_\_\_\_\_

Reason for taking: \_\_\_\_\_



Camper's name \_\_\_\_\_

**This form must be presented to your Physician for Completion**

**Health Care Recommendations by Licensed Medical Personnel**

I examined the individual on \_\_\_\_\_. (ACA Accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.)

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant  is  is not able to participate in an active camp program. The applicant is under the care of a physician for the following conditions:

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**Recommendations and Restrictions at camp**

Treatment to be continued at camp

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Medications to be continued at camp

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Any medically-prescribed meal plan or dietary restrictions

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Known allergies

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Description of any limitation or restriction on camp activities

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Additional information for health care staff at the camp

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**Signature of Licensed Medical Personnel**

Print name

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Address

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Phone

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Date

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**Camper Information**

**NAME:** \_\_\_\_\_

**NICKNAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**What do you hope your child gains from this camp experience?**

**How would you describe your child's self-esteem?**

**What would you like your child's counselor to know about your child that would make the experience a better one? (Include information that makes your child happy/unhappy, certain fears, etc.)**

**Does your child have any behaviors that we should know about?**

**What grade level does your child function at?** \_\_\_\_\_

**Is your child in special education or does he/she have an IEP?** \_\_\_\_\_

**Is there a specific educational area in which your child receives extra assistance?**

**If placed in a combined age group, would it be more appropriate to group your child with slightly older or slightly younger children?**

Does your child require assistance with any of the following activities of daily living? \_\_\_\_\_  
 If yes, please indicate and describe below.

		NEVER	SOMETIMES	ALWAYS
<b>HYGIENE</b>				
	SHOWERING			
	TOILETING			
	BRUSHING TEETH			
<b>DRESSING</b>				
	FASTENING SHOES			
	BUTTONS/ZIPPERS			
<b>WALKING</b>				
	ADAPTIVE DEVICE			
	e.g. splint, brace			
<b>MEAL TIME</b>				
	ASSISTANCE WITH			
	UTENSILS			
	POURING LIQUIDS			
	FOOD CHOICES			
<b>OTHER (please list)</b>				

Please describe any of the activities above that require assistance some or all of the time.

Does your child need a reminder for toileting?

Does your child use a shower chair for safety?

Is your child incontinent at night? (Due to seizures or even with medications that induce a deep sleep) If yes, please be specific about your regimen at night, which could include frequent trips to the bathroom, pads or diapers.

(Please send your child with the appropriate protection for incontinence; bear in mind that bathroom facilities are not attached to the bunk)

Is your daughter able to care for her needs independently during her menses?

(Please send an appropriate supply of protection)

What is your child's usual bedtime? \_\_\_\_\_

What is a usual wake-up time? \_\_\_\_\_

Does your child require a nap during the day? (this is excluding a nap after a seizure)

Does your child have trouble sleeping through the night or have nightmares?

Camp Wee-Kan-Tu

Camper's name \_\_\_\_\_

Does your child sleepwalk or speak while sleeping?

Does your child wear a helmet for protection?

Does your child have one of the following, circle all that apply: Eyeglasses; Contact lenses; Protective eyewear; Hearing aid(s); Retainer for teeth; Night brace or any other device that we should know about?

Please use this extra space to elaborate on any of the above questions or anything else that you would like us to know. This will help us to make your child's experience a happy and safe one.

**FOR NEW CAMPERS:** Please tell us how you feel your child will react to this camping experience.

**FOR RETURNING CAMPERS:** What programs were the most enjoyed in the previous year(s) at Camp Wee-Kan-Tu?

**SEIZURE INFORMATION**

Please describe in detail what your child's seizure(s) look like. Be sure to note if your child has:

- More than one type of seizure (describe each type)
- Include facial/eye/body movements
- Level of awareness
- Incontinence of bowel or bladder

Have you identified any seizure triggers for your child?

- Lack of sleep
- Stress
- Smells
- Loud noises
- Menstrual cycle
- Other \_\_\_\_\_

Does your child have any warning sign/aura/behavioral change prior to a seizure?

What might we see just before a seizure?

Does your child try to alert anyone?

What is a typical length of a seizure? (dependent on type)

When have you been instructed to give "rescue" medications?  
Diatat/Ativan How often in a 24 hour period?

What is your usual threshold for notifying a physician/transport to the closest emergency room?

Does your child experience seizure clusters? If there is a single or cluster of seizures, is this a precursor for more the same day? What is the usual pattern?

Do they tend to occur at a particular time of day? Upon waking, at bedtime or while sleeping?

What is your child like after a seizure and what can we expect to provide?

Does your child sleep for a specific amount of time? Are they emotional? (tears or anger) Please be descriptive so we may offer a safe and familiar plan for your child.