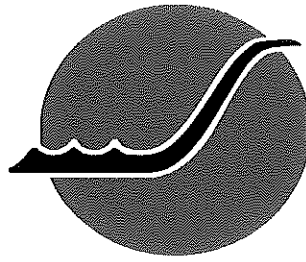


FOR OFFICE USE ONLY

CAMP # _____
DEPOSIT _____
CK# _____



2018 GLISSON CAMP AND RETREAT CENTER: SPARROWWOOD APPLICATION

First Choice: Session _____ Date _____

Second Choice: Session _____ Date _____

Third Choice: Session _____ Date _____

Camper's Full Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Date and Place of Birth: _____ **Age:** _____

Height: _____ **Weight:** _____ **T-shirt size:** _____ **Gender:** _____ **Ethnicity (optional):** _____

Camper lives with: _____ **Relation:** _____

School or Center Camper Attends: _____

Church Affiliation: _____ **Years attended Sparrowwood:** _____

Type of residence: Private: _____ Group Home: _____ Institution: _____ Other: _____

If your camper is over the age of 18, do they have a personal representative? _____ If yes, please include the name and phone number below:

Personal Representative: _____ **Phone:** _____

Parents/Guardian's Names:

Current Address if different:

Parent or Guardian

Phone: (day) _____ (night) _____

(cell) _____ (Email) _____

Emergency Contact: _____

Phone: (day) _____ (night) _____

(cell) _____

Social Worker(if applicable): _____

Phone: (office) _____ (home) _____

(cell) _____ (Email) _____

Cabin Mate request _____

What are two areas that you would like to see growth and learning from your camper during their week at camp?

1. _____

2. _____

****Please attach a recent picture of your camper to aid us with greeting him/her at check-in.**

Basic Camper Criteria

Physical Abilities

1. All Applicants Must Be Ambulatory.
2. Able to function in a program involving lots of walking/hiking, swimming, boating, archery, etc.

Self- Help Skills

1. Uses toilet appropriately (able to wipe self and regulate bathroom needs through the night). Episodes of incontinence are not normal.
2. Capable of washing, dressing, and eating independently (or with minimal help).
3. Females: Has an understanding and awareness of, is able to cope with, and independently provides necessary hygiene during menstrual cycle.

Social Skills

1. Able to communicate needs whether verbally or non-verbally.
2. Able to relate appropriately to other campers and leadership in a *structured* program with a 1:2 staff to camper ratio.
3. Able to stay within physical boundaries of camp setting with no wandering.
4. Free from any self-abusive or aggressive behaviors towards others.

Medical Conditions

1. Seizures – controlled (no more than one seizure per month).
2. Able to eat most normal adult table foods (controlled diabetics acceptable).

I have read the above, and this camper meets the criteria listed. (Please initial here) _____

Camper's Name (Goes by) _____

CAMPER INFORMATION SECTION

THIS INFORMATION SECTION MUST BE FULLY COMPLETED FOR **FIRST TIME AND RETURNING CAMPERS**, IN ORDER TO PROVIDE COUNSELORS WITH INFORMATION NECESSARY TO MAKE THE CAMPING EXPERIENCE MOST BENEFICIAL. THIS APPLICATION WILL NOT BE CONSIDERED IF IT IS RETURNED INCOMPLETE, WITHOUT THE ENCLOSED MEDICAL FORM OR THE REQUIRED DEPOSIT.

Please attach most recent Psycho-Social Evaluation

MEDICAL HISTORY: (Please check the appropriate places and explain as necessary.)

Primary Diagnosis: _____

Intelligence Quotient: () Mild (IQ 70-50) () Moderate (IQ 50-40) () Severe (IQ 40-20)

<u>Condition</u>	<u>Acute</u>	<u>Chronic</u>	<u>Explanation, including any physical or functional disability</u>
Tuberculosis	()	()	_____
Hepatitis B	()	()	_____
Bleeding Disorders	()	()	_____
Rheumatic Fever	()	()	_____
HIV Positive	()	()	_____
Heart Disease	()	()	_____
Asthma	()	()	_____
Other	()	()	_____

Does the camper have any food or drug allergies? () YES () NO

If yes, please list: _____

Reaction? _____

Does the camper have a history of Diabetes? () YES () NO

If yes, how is it controlled? _____

Does the camper have a history of seizures? () YES () NO

If yes, how is it controlled? _____

Describe behavior before, during, and after the seizure: _____

Any hospitalizations, accidents, surgery, or serious illness within the past 12 months? () YES () NO

If yes, please explain: _____

In the unusual case that your camper should be injured at camp, please describe the typical pain response. (i.e. does not communicate pain, has very high tolerance for pain, or over dramatizes the situation.)

Is skilled health care required for this person other than administration of medication? () YES () NO
If yes, what kind of care? _____

SKILLS FOR DAILY LIVING (The following information will allow us to plan appropriate activities that will help ensure a positive camp experience. Please be specific in your answers, and use another piece of paper if necessary.)

Behavior & Peer Relations

Relates to others () Well () Poorly

Explain: _____

Agitated in large groups or by large amounts of noise: () Never () Seldom () Often

Explain: _____

Displays of physically self-abusive behavior within the past 12 months? () NO () YES

Explain: _____

Displays of physically/sexually aggressive behavior towards others in the past 12 months? () NO () YES

Explain: _____

What might prompt these inappropriate behaviors? _____

Positive ways to motivate camper: _____

Please note any fears or frustrations which may lead to behavior problems: _____

Speech & Communication

() Verbal () Non-Verbal () Signing () Points, grunts, etc. () Verbalizes basic needs

If camper is non-verbal, please explain in detail their ability to communicate and how best to communicate with them:

Describe any limitation in the following areas:

Vision _____

Hearing _____

Comprehension & Memory

Know own name: () YES () NO

Follows simple directions: () YES () NO

Oriented to time and place: () YES () NO

Mobility

Is the applicant able to participate in the normal pace of activities (walking, hiking, sports, swimming, etc.) or do exceptions need to be made for a slower pace (more rest, sitting out of some activities, etc.)?

() Little or no rest between activities () Some rest between activities () A lot of rest between activities

Limitations in Gross Motor Skills (i.e., walking, running) _____

Camper's Name (Goes by) _____

Limitations in Fine Motor Skills (i.e., writing, drawing, buttons/zippers) _____

Eating Patterns

() Totally Independent () Minimal Assistance () Cannot feed self () Other (include food allergies)
Able to eat regular diet () Yes () No
Requires special diet () Yes () No If yes, specify: _____

Sleeping Patterns

() Normal () Restless () Hard to wake () Talks in Sleep () Wanders/Sleepwalks
Explain: _____

What helps your camper get to sleep? _____

Grooming: (5 is total self-sufficient, 1 is total reliance)

Circle One:	Self-Sufficient		Some assistance required		Complete Reliance on Staff
Showering	5	4	3	2	1
Dressing	5	4	3	2	1
Dental care	5	4	3	2	1
Using toilet	5	4	3	2	1
Menstrual care*	5	4	3	2	1

(*for females only)

ESSENTIAL INFORMATION WITHHELD IN REGARDS TO THE EXTENT OF THE CAMPER'S DISABILITIES, RESULTING IN INJURY TO SELF OR OTHER CAMPERS, OR DAMAGE TO THE CAMP PROPERTY, WILL BE CONSIDERED THE FINANCIAL/LEGAL RESPONSIBILITY OF THE PARENT, GUARDIAN, OR CARE PROVIDER.

Name of Person Completing this Application:

Name: _____ Relationship: _____ Phone: _____

Signature: _____ Date: _____

Agency: _____ Phone: _____

MEDICATION RECORD

It is vitally important that all prescribed medications are brought to camp in their original packaging with current dosage from the pharmacy, with the camper's name and doctor's name clearly visible. Campers will not be permitted to stay if medications are pre-packaged in any type of cassettes, baggies, envelopes, etc. While at camp, the camp nurse will oversee the administration of all medications except for inhalers, prescription creams, shampoos, or oral rinses.

I give permission to the healthcare team to administer and oversee the administration of prescription medication (as noted below) and over-the-counter medication (PRNs).

SIGNATURE: _____

DATE: _____

Please share in the space below medications that your camper routinely takes. Our healthcare team will use this information to prepare for your camper's arrival and to ensure they have an opportunity to ask any questions needed prior to your arrival. (At check-in you will bring with you a filled out Glisson Check-In Form that will have more detailed information.)

Name of Drug

Example: Mellaril

Times Given

Breakfast and dinner

Reason for Medication

Behavior

Background checks are required for campers and staff 18 years of age and older and will be processed at the expense of North Georgia Camp and Retreat Ministries. Information returned through background checks will be utilized as a part of the camper application process and may result in our inability to approve a camper's application for Sparrowwood. Please fill out the following information in its entirety.

FOR CAMPERS 18 YEARS OF AGE AND OLDER ONLY:

I hereby authorize Glisson Camp and Retreat Center to request CampBackgroundCheck.com Inc. or any entity chosen by the camp specifically for conducting this search to release information regarding any record of charges or convictions contained in its files, or in any criminal file maintained on this adult camper whether said file is a local, state, or national file, and including but not limited to accusations and convictions for crimes committed against minors, to the fullest extent permitted by state and federal law. I do release CampBackgroundCheck.com Inc. and other entities from all liability that may result from any such disclosure made in response to this request.

Signature of adult camper or legal guardian

Date

Print adult camper's full name: _____

Print all other names that have been used by applicant (if any): _____

Street address: _____

City, State, Zip: _____

Social Security #: _____

Date of Birth: _____

Place of birth: _____

If applicable:

Driver's license #: _____

State issuing license: _____

License expiration date: _____

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Mail this form to the address below by _____ (date)

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last
 Male Female Birth Date _____ Age on arrival at camp: _____
Month/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

- 1) Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.
- 2) Send the original, signed FORM 1 to camp by the requested date.
- 3) Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.
- 4) After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.

Camper Home Address: _____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) (_____) _____
Relationship to Camper
 Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) (_____) _____
Relationship to Camper
 Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): _____ Relationship to Camper: _____ Preferred Phones: (_____) (_____) _____
Relationship to Camper

Allergies: No known allergies. This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: This camper eats a regular diet. This camper eats a regular vegetarian diet.
 This camper has special food needs. *(Please describe below.)*

Restrictions: I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. *(Please describe below.)*

Medical Insurance Information:

This camper is covered by family medical/hospital insurance Yes No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company _____ Policy Number _____
 Subscriber _____ Insurance Company Phone Number (_____) _____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Camper: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Camper Name

First

Middle

Last

(For Camp Use) Cabin or Group _____

(For Camp Use) Session Code(s): _____

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Camper Name: _____
 First Middle Last
 Birth Date: _____
 Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis* (DTaP) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella* (MMR)						
Polio* (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test Date: _____ Negative Positive

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

Medication: This camper will not take any daily medications while attending camp.

This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.**

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those the camper should not be given.**

- | | |
|---|---|
| Acetaminophen (Tylenol) | Ibuprofen (Advil, Motrin) |
| Phenylephrine decongestant (Sudafed PE) | Pseudoephedrine decongestant (Sudafed) |
| Antihistamine/allergy medicine | Guaifenesin cough syrup (Robitussin) |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Dextromethorphan cough syrup (Robitussin DM) |
| Sore throat spray | Generic cough drops |
| Lice shampoo or cream (Nix or Elimite) | Antibiotic cream |
| Calamine lotion | Aloe |
| Laxatives for constipation (Ex-Lax) | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Camper Name: _____
First Middle Last
Birth Date: _____
Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

- | | |
|---|---|
| 1. Ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had fainting or dizziness? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? Yes No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... Yes No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?..... Yes No
4. Had a significant life event that continues to affect the camper's life?..... Yes No
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (_____) _____
Name of dentist(s): _____ Phone: (_____) _____
Name of orthodontist(s): _____ Phone: (_____) _____

What Have We Forgotten to Ask? Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. **Attach additional information if needed.**

Parents/Guardians: STOP here. The rest of this form is completed when the camper arrives at camp. Keep a copy for your records.

**CAMPER HEALTH-CARE RECOMMENDATIONS
by LICENSED MEDICAL PERSONNEL FORM 2**

Developed and reviewed by: American Camp Association
American Academy of Pediatrics, Council on School Health, &
Association of Camp Directors

Mail this form to the address below by _____ (date)

To Parent(s)/Guardian(s): Complete this section and give this form (FORM 2) and a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1) to your child's health-care provider for review.

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last

Male Female Birth Date _____ Age on arrival at camp _____
Month/Day/Year

Camper home address: _____

City _____ State _____ Zip Code _____

Custodial parent(s)/guardian(s) phone: (____) _____ (____) _____

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. Medical personnel: Cross out those items the camper should not be given.

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)
- Chlorpheniramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimite)
- Calamine lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today: Yes No (If "No," date of last physical: _____)
Month/Day/Year

ACA accreditation standards specify physical exam within last 24 months.

Weight: _____ lbs Height: _____ ft _____ in Blood Pressure _____ / _____

Allergies: No Known Allergies

To foods (list):

To medications: (list):

To the environment (insect stings, hay fever, etc.-- list):

Other allergies: (list):

Describe previous reactions:

Diet, Nutrition: Eats a regular diet. Has a medically prescribed meal plan or dietary restrictions: (describe below)

The camper is undergoing treatment at this time for the following conditions: (describe below) None.

Medication: No daily medications. Will take the following prescribed medication(s) while at camp: (name, dose, frequency—describe below)

Other treatments/therapies to be continued at camp: (describe below) None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? No Yes

If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically, emotionally, and socially fit to participate in an active camp program (except as noted above)."

Name of licensed provider (Please print): _____ Date: _____

Signature: _____ Phone: _____

Office address _____

Camper Name _____

First

Middle

Last

(For Camp Use) Cabin or Group _____

(For Camp Use) Session Code(s): _____

Sparrowwood Packing List

Luggage:

Large duffel bag or suitcase

Outerwear:

Rain jacket or poncho

Sweatshirt/ Light Jacket

Footwear:

Closed toe shoes(required for adventure activities)

Water shoes with heel strap

Extra pair of shoes in case of rain

Camp Clothing:

Comfortable camp clothes for **six** days (shorts and t shirts are the norm)

1 pair of pants/jeans (required if attending horse camp)

Socks & underwear

One-piece swim suit

Hat/bandana

Sleeping:

Sleeping bag OR bedding for single and double bed

Pillow

Pajamas

Camp Gear:

Water bottle (leak proof)

Flashlight/headlamp

Day pack

Insect repellent

Sunscreen/lip balm

Personal Items:

Washcloths

Towels/Beach towel

Toiletries (soap, shampoo, toothbrush/toothpaste, etc.)

Optional Items:

Camera

Musical instrument

Large plastic bag for wet/dirty clothes

Medication:

Prescription medications: Please follow directions on medication form.

Remember all medications must be in original packaging.

Label all clothes and personal items before you come to camp!

DO NOT BRING: Cell phones or devices with screens, music players, tobacco, alcohol, drugs, fireworks, firearms, pets, flip flops, water guns, any expensive or valuable personal items