



# Precious Jewels Week 2017 Application Form

Camper \_\_\_\_\_ Age \_\_\_\_\_  M  F DOB \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

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

Has the camper attended BaYouCa before? \_\_Yes \_\_No Last year attended: 2016\_\_ Other: \_\_\_\_\_

Care Provider \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Care Provider E-mail address \_\_\_\_\_

Relationship to Camper: (FCP, parent, sibling, House Manager, etc.) \_\_\_\_\_

**Make check or money order payable to: Bayouca**

**Mail to: Camp Bayouca 100 Camp Spaulding Rd. Smithville Flats, NY 13841**

**Questions? Call - (607) 656-9701 Fax- (607) 656-9910 office@bayouca.com www.bayouca.com**

**Application/Registration Fee: \$50.00**

**Due on Arrival: \$370.00**

**TOTAL FEE: \$420.00**

-----**Office Use Only**-----

Pre-Reg \$ \_\_\_\_\_ Balance Due: \_\_\_\_\_ Postmarked: \_\_\_\_\_

CCR \_\_\_\_\_ PCR \_\_\_\_\_ CC \_\_\_\_\_ PC \_\_\_\_\_ DDS \_\_\_\_\_ MO \_\_\_\_\_ Health Form \_\_\_\_\_

Cabin # \_\_\_\_\_ Spending \$ \_\_\_\_\_

**Camper Profile - please complete to the best of your knowledge**

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

Does the camper require hourly nighttime bed checks? Yes  No

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 & Face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tying Shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does the individual wear glasses?  Yes  No

Does the individual wear hearing aids?  Yes  No

Does the individual wear Dentures?  Yes  No

May we give/help apply bug repellent and/or sunscreen to your camper, as needed?  Yes  No

Please provide any other necessary information: \_\_\_\_\_

**5. Eating (Please check all that apply)**

Eats independently  Needs help eating  Overeats

Needs food cut up (quarter sized)  Needs food chopped (dime size)  Pureed (strict soft diet)

Needs meats cut up *only*  Uses Thick-it for drinks  Uses straw for liquids

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

Please explain any other information regarding eating habits: \_\_\_\_\_

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

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

Please specify diabetic diet restrictions/modifications: \_\_\_\_\_

**6. Camper Health (Please check all that apply)**

**Allergies:** \_\_\_\_\_

**Frequent UTI**  **Frequent Diarrhea**  **Frequent Constipation**  **Heart Defect/Disease**  **Hypertension**  **Headaches**

**Bleeding/Clotting Disorders**  **Psychiatric Treatment**  **Mononucleosis**  **Asthma**

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

**Rheumatic Fever**  **Other (Specify)** \_\_\_\_\_

**Seizures (Specify)**  **Simple (minor motor skills affected, no loss of awareness)**  **Complex (Loss of awareness)**

**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 Bayouca Program accepts children starting at 8 years old - adults with developmental disabilities who are without aggressive behavior, can communicate their needs, and are ambulatory and independent in eating and toileting. The camper should be able to participate in the program. Rules for acceptance in the program are equal for everyone without regard to race, color, sex, age, or national origin.

Active  Excitable  Behaves  Listens  Helpful  Participates  Cooperative  
 Inquisitive  Passive  Quiet  Follows Instructions  Tantrums  Refuses  
 Stubborn  PICA  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.

**NOTE: Even if the camper has attended before, his/her counselor for the week may be new or unfamiliar with the camper. It is best to be thorough so staff can better understand the camper’s unique needs.**

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.**

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

**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.

Basketball	Yes ( )	No ( )	Volleyball	Yes ( )	No ( )
Nature Walks/Hikes	Yes ( )	No ( )	Kickball	Yes ( )	No ( )
Fishing	Yes ( )	No ( )	Hay Ride	Yes ( )	No ( )
Paddle Boats	Yes ( )	No ( )			

**11. Physical / Medical Information**

Please enclose the most recent complete physical examination and list of current medicines with the Application/Registration Form.

**NOTE:** If you are unable to do so please state why and give *date that the physical is scheduled*.

Reason: \_\_\_\_\_ Date Scheduled: \_\_\_\_\_

**12. Immunization Records**

Please complete this section or attach an up to date Immunization Record.

Please fill in month & year of your camper's immunizations.

MMR \_\_\_/\_\_\_ \_\_\_/\_\_\_ DPT \_\_\_/\_\_\_ \_\_\_/\_\_\_ \_\_\_/\_\_\_ Hib \_\_\_/\_\_\_ \_\_\_/\_\_\_ Hep B \_\_\_/\_\_\_ \_\_\_/\_\_\_ \_\_\_/\_\_\_  
VZV \_\_\_/\_\_\_ \_\_\_/\_\_\_ \_\_\_/\_\_\_ (camper had chicken pox. Date \_\_\_/\_\_\_) OPV/IPV \_\_\_/\_\_\_ \_\_\_/\_\_\_ \_\_\_/\_\_\_

**13. 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: \_\_\_\_\_

**14. 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 director 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.
- G.** May we give/help apply bug repellent and sun screen to your camper, as needed? \_\_\_ Yes \_\_\_ No

**Signature:** \_\_\_\_\_ **Please print name:** \_\_\_\_\_

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

After review of the preceding information, the camp director or health director will make a decision regarding acceptance into the camp program. **All necessary paperwork must be completed, signed, and submitted by June 1.** If the camper is accepted, you will receive a confirmation letter, medicine administration form, and list of what to bring to camp. The registration fee will be refunded if the camper is denied acceptance to the program.