Summer 2017
Achieve Camps
Camp is limited to 40 campers

July 25-29 for campers ages 8-102

Registration Information

Camper Name ________________________________ Nickname? ___________________________
Address ____
City __________________________ State ____________ Zip Code ______________
Phone _________________________ Email ____
Date of Birth ____________________________ Age ________________ Gender: Male / Female
Disability Type(s) ____
T Shirt size _____________
Who will be paying for camp? (ie cash, cdc) _______________________________
Legal Guardian(s) Name____
Address____
City ______________________________ State ____________ Zip Code _______________
Home Phone ___________________Cell Phone ________________Work Phone ________________
Email ____
Preferred Contact Method: **Phone** or **Email** (please circle)

Camper Information

Please help us understand the needs or your camper by describing level of assistance needed and other helpful information:

1. Dressing: ____
2. Eating: ____
3. Toileting: (indicate if and when diapers are used)
   ____
4. Walking? (indicate if unsteady or if special equipment is used)
   ____
5. Does the camper have difficulty sleeping?
   ____
6. Does the camper have difficulty hearing? (indicate if hearing aids are used)
   ____
7. Does the camper have seizures? **Y** or **N** if yes, how frequently ______________
   number in last 12 months _____ type of seizure ______________ date of last seizure ____________
   seizure protocol?:____

Camper History

Does your camper have any history of:

1. Emotional or behavioral problems? (list possible causes/methods to improve behavior)

   ____

2. Admission to a facility due to emotional/behavioral problems in the last 12 months?

   ____

3. Hurting themselves, others or property destruction?

   ____

4. Being extremely active, nervous or anxious?

   ____

5. Non-compliance?

   ____

6. Temper tantrums?

   ____

7. Wandering away from a group?

   ____

8. Treatment for ADD or ADHD?

   ____

10. How does the camper communicate? ❑ Talking ❑ Signing ❑ Gestures ❑ Other ________________

Health Information

Medical Insurance: please attach a copy of the insurance card(s) with front and back views.

Is camper covered by medical/hospital insurance? No / Yes (if yes, fill out information below)

Insurance Company ____

Policy Number ____

Insurance Company Address _____________________________________

Phone ____

Name of Policy Holder ____

Relationship ____

Emergency Contact Information: if legal guardian listed above cannot be reached or is not the primary emergency contact

Name ____ Relationship _____________________________

Home Phone ___________________ Cell Phone__________________ Work Phone __________________

Health History

Assessment of Abilities

No	Yes	*Can the camper:*
❍	❍	1. Run?
❍	❍	2. Walk three blocks without tiring?
❍	❍	3. Swim?
❍	❍	4. Follow simple directions?
❍	❍	5. Bathe without direction?
❍	❍	6. Dress self and tie shoes?
❍	❍	7. Use the toilet without reminder or assistance?
❍	❍	8. Feed self without assistance?

No	Yes	*Does the camper:*
❍	❍	9. Usually express needs verbally?
❍	❍	10. Only use single word utterances?
❍	❍	11. Smoke cigarettes, cigars or a pipe?

No	Yes	*Is the camper:*
❍	❍	12. Responsive to people?
❍	❍	13. Continent during the day?
❍	❍	14. Continent at night?

Explain any restrictions to activity (e.g., what can't be done, what adaptations or limitations are necessary, etc.)

____

____

General Health Information

No	Yes	*Has the camper ever:*
❍	❍	1. Had any recent surgery, illness or infectious disease?
❍	❍	2. Been hospitalized?
❍	❍	3. Had surgery?
❍	❍	4. Had a head injury?
❍	❍	5. Been knocked unconscious?
❍	❍	6. Had frequent ear infections?
❍	❍	7. Passed out during/after exercise?
❍	❍	8. Been dizzy during/after exercise?
❍	❍	9. Had chest pain during/after exercise?
❍	❍	10. Had seizures?
❍	❍	11. Had high blood pressure?
❍	❍	12. Been diagnosed with a heart murmur?
❍	❍	13. Had mononucleosis in the past 12 months?
❍	❍	14. Had an eating disorder?
❍	❍	15. Had emotional difficulties for which professional help was sought?

No	Yes	*Does the camper:*
❍	❍	16. Have a chronic or recurring illness/condition?
❍	❍	17. Have frequent headaches?
❍	❍	18. Wear glasses, contacts or protective eye wear?
❍	❍	19. Have orthodontic appliances he or she is bringing to camp?
❍	❍	20. Have any skin problems (e.g., itching, rash, acne)?
❍	❍	21. Have diabetes?
❍	❍	22. Require Accu-Checks?
❍	❍	23. Have asthma?
❍	❍	24. Require a nebulizer?
❍	❍	25. Have back problems?
❍	❍	26. Have problems with joints (e.g., knees, ankles)?
❍	❍	27. Have problems with sleepwalking?
❍	❍	28. Have an abnormal menstruation history?
❍	❍	29. Have problems with diarrhea or constipation?
❍	❍	30. Have a history of bed-wetting?

In this section, please ***explain any "yes" answer(s)*** *on a separate sheet of paper, noting the question number.*

Allergies

Does the camper have any known allergies? ❍ No ❍ Yes *(if yes, fill out information below)*

List of known allergies	Describe reaction and management of reaction

Special Dietary Needs

Food Restrictions: *types of food, dairy, food allergies*

Food Aversions:

Food Preferences:

Food Constancy:

Solid Puree Soft Mechanical Other: ______________________________

We make every effort to meet each specific dietary needs of your camper. We will contact you if we have any questions or can not accommodate a certain need. Please contact us with any questions.

Medications / Vaccinations

Medications:

Please complete the ***"Medication Report"***. List any additional information on back of report. All medications are administered by a registered nurse and must come in their original containers.

Vaccinations:

No	Yes	*Has the camper had:*
❍	❍	Measles?
❍	❍	Chicken Pox?
❍	❍	German Measles?
❍	❍	Mumps?
❍	❍	Hepatitis A?
❍	❍	Hepatitis B?
❍	❍	Hepatitis C?

PPD Test

Date of last test ______________

Result ❍ Positive ❍ Negative

Please give ***all dates*** of immunization for each vaccine listed below.

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DPT					
TD (tetanus/diphtheria)					
Tetanus					
Polio					
MMR					
or Measles					
or Mumps					
or Rubella					
Haemophilus influenza B					
Hepatitis B					
Varicella (chicken pox)					

Authorization

I have read this application and give permission for ______________________ to attend Camp Bighorn's Achieve Camps and engage in all activities except as noted. This health history, medication report is complete and correct to the best of my knowledge. I give Camp Bighorn permission to administer prescribed medication(s), over-the-counter medications and first aid; to seek medical treatment, including x-rays, hospitalization, or tests as needed; and to provide nursing care while camper is at camp. I agree that Camp Bighorn can arrange for necessary transportation related to medical needs. I understand and agree to abide by any restrictions placed on participations of camp ac activities.

Legal Guardians Signature ____________________________

Relation to camper ___________________

Date ___________________

Camp Cost $295

5% off if they register (paperwork and deposit) by March 1st.
An additional 5% if they also pay in full by March 1st.
An additional 5% off for family members

Please return registration by July 1 Thank you

Mail Registrations:
Make checks payable to Camp Bighorn
1850 MT HWY 135
Plains, MT 59859

406-826-3144
www.campbighorn.com

Camp Bighorn Liability Release

BY SIGNING THIS FORM, I hereby acknowledge the inherent risks involved with outdoor adventure and ropes course activities. I do hereby voluntarily participate in the programs offered. I and the participant signed below release and discharge Camp Bighorn from all action that they as a participant, their heirs, guardians, and legal representatives now have or may hereafter have for injury or damages sustained. I acknowledge that I have carefully read this agreement and I give Camp Bighorn permission to use any photo or video of myself or my child for Camp Bighorn publications or promotional advertising,unless otherwise requested. I release my right to any kind of remuneration for said photos or videos.

____

Participant's Name

____

Adult Participant OR Signature of Parent or Guardian (if participant is a minor)

____

Name Printed

____

Date

Achieve Camps Medication Report

BRING THIS FORM TO CAMP enclosed in a GALLON SIZE zip-lock bag with all MEDICATION

Camper Name ____________________

Camp Dates ____________________ **Page** ______ **of** ______

SIGNATURE REQUIRED ____________________

Medication Report must match dosage sent. All over the counter medication must be sent for your child. This includes, tylenol, etc. NO medications are provided.

For Nurse Only
Do Not Write In Area Below

Medication 1	Dosage	√	Time	Day 1	Day 2	Day 3	Day 4	Day 5
	_____ mg		8:00 AM					
			12:00 PM					
			3:00 PM					
			6:00 PM					
PARENTS Please VERIFY the number of pills sent	___ PILLS		9:00 PM					
			PRN					
Medication 2	**Dosage**	**√**	**Time**	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**
	_____ mg		8:00 AM					
			12:00 PM					
			3:00 PM					
			6:00 PM					
PARENTS Please VERIFY the number of pills sent	___ PILLS		9:00 PM					
			PRN					
Medication 3	**Dosage**	**√**	**Time**	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**
	_____ mg		8:00 AM					
			12:00 PM					
			3:00 PM					
			6:00 PM					
PARENTS Please VERIFY the number of pills sent	___ PILLS		9:00 PM					
			PRN					
Medication 4	**Dosage**	**√**	**Time**	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**
	_____ mg		8:00 AM					
			12:00 PM					
			3:00 PM					
			6:00 PM					
PARENTS Please VERIFY the number of pills sent	___ PILLS		9:00 PM					
			PRN					
Medication 5	**Dosage**	**√**	**Time**	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**
	_____ mg		8:00 AM					
			12:00 PM					
			3:00 PM					
			6:00 PM					
PARENTS Please VERIFY the number of pills sent	___ PILLS		9:00 PM					
			PRN					

ALL MEDICATIONS MUST BE IN THEIR ORIGINAL CONTAINERS