

PHYSICAL LIMITATIONS:

Does this person require a wheelchair/walker/cane/prosthesis: _____

Please describe equipment & when used: _____

Describe how transfers are done: _____

Difficulty walking: _____

Wears glasses: _____ Legally Blind: _____

When are glasses required: _____

Physical description of glasses: _____

Hearing: _____ Hearing Aids: _____ Which Ear: _____

If Down Syndrome, do they have Atlanta-Axial Stability: _____

Dental: Do they have dentures, partial plate, caps, etc. Describe location and care required: _____

Do they wear diapers: _____ When: _____

If 24 hrs do they still use the toilet: _____

Is bed wetting a concern: _____ How often: _____

Please list all previous medical history, diagnosis, surgeries, conditions, etc.: _____

Has this person been under medical care in the last year: _____

Is this person under medical care at the present time: _____

Reason: _____

Please note any limitations: _____

Please list activities this person **MAY NOT** participate in:

EPILEPSY:

Grand Mal: _____ Petit Mal: _____

Frequency & length: _____

Date of last seizure: _____ Helmet required: _____

When is helmet used: _____

Medical protocol followed: _____

DIABETES:

Controlled by: diet (attach copy) _____

Oral medication _____

Insulin (frequency) _____

Glucometer Readings (frequency) _____

Amount of assistance required: _____

Range of sugar levels: _____

MENSTRUAL CRAMPS:

Describe usual medications and/or treatment: _____

ALLERGIES:

Food, drugs, insects, pollen: List _____

Reactions/severity: _____

Severity: (mild, moderate, severe): _____

Describe treatment and medication: _____

EPIPEN: _____

ASTHMA:

Describe treatment, limitations and medications:

IMMUNIZATION: Is immunization up to date: YES _____ NO _____

Date of last Tetanus (required every 10 years) _____

Vaccination for Hepatitis "B" or "C": _____

HEART DISEASE/HIGH BLOOD PRESSURE:

Please describe history, diagnosis and present limitations: _____

Usual blood pressure if known: _____

Blood Type if known: _____

EARS/EYES/NOSE/THROAT:

Describe usual medication and/or treatment: _____

Special care in swimming pool: _____

STOMACH PAINS/HEADACHES:

Describe usual medications and/or treatment: _____

FUNGUS INFECTIONS/ATHLETES FOOT:

Describe usual medications and/or treatment: _____

FAINTING SPELLS:

Describe treatment: _____

BOWEL MOVEMENTS:

Describe usual frequency, medication and/or treatment: _____

SLEEPING CONCERNS:

How managed: _____

Usual bedtime: _____ Usual wake up time: _____

EATING (SPECIAL DIETS, FOOD CUT & ADAPTIVE DEVICES):

List in Detail and Attach Copy: _____

(special foods must to be provided ex. Gluton &/or lactose free, supplements, thickener)

SMOKER:

Is this person a smoker or non-smoker: _____

Describe smoking habit, program, etc. _____

APPLICATION AND MEDICAL INFORMATION CONTINUED
BEHAVIOURAL, EMOTIONAL, PSYCHIATRIC CONCERNS:

Please check and describe:

Biting: _____

Spitting: _____

Wandering: _____

Self Injurious: _____

Striking out at others: _____

Hallucinations: _____

Refusal of medications: _____

Other: _____

Please offer suggestions of how to deal with any such concerns: _____

Describe any scars or identifying marks: _____

Person's Weight: _____ Person's Height: _____

Staff/camper ratio provided at home: _____

Any other helpful information for the camp health staff & counsellors: _____

PLEASE: If needed write us a letter on a separate page telling us how better to give consistent care to the camper/lodger.

PLEASE NOTE: Behaviour protocols must be received with this application. Behaviour and medical difficulties or concerns not described accurately may necessitate early return of camper or lodger.

HELPFUL HINTS FOR HAPPIER CAMPERS

What activities (ie. Sports, crafts, campfires, hikes, etc.) will he/she enjoy:

Hate or fear: _____

What foods does he/she love: _____

What foods does he/she hate: _____

What techniques do you use if refusing meals: _____

What conversation topics does he/she like to discuss: _____

What conversation topics should we avoid: _____

What strategies might we use if he/she is unhappy: _____

Please describe how pain/illness/hunger/tiredness is communicated?

Please describe strategies we may use to deal with these behaviour concerns (be very specific):

Please describe this person's language skills and techniques: (ie. Verbal, sign language, pics, gestures, etc.) _____

LIVING SKILLS

SKILLS	MUST BE DONE FOR THEM	HAND OVER HAND	VERBAL DIRECTIONS	INDEPENDENT
Tooth Brushing				
Dentures				
Face Washing				
Toileting				
Eating				
Showering				
Dressing				
Hearing Aid Care				
Care of Eyeglasses				
Shaving (type of razor)				
Diapers				
Menstrual Care				

PLEASE ADD FURTHER COMMENTS ON SPECIAL NEEDS OR CARE:

WHAT DO YOU DO IF THEY REFUSE HYGIENE CARE?

PERMISSION

HEALTH CHECKS:

I hereby grant permission for the Health Staff or Senior Counsellor to examine the camper/lodger visually upon arrival and departure for signs of infection/illness.

DATE: _____ SIGNATURE: _____

PICTURES:

I hereby grant permission for pictures or movies to be taken of the camper/lodger and I would allow them to be seen in the camp newspaper, on our website, shown in public and used for advertising/fundraising.

DATE: _____ SIGNATURE: _____

ALCOHOL:

I hereby grant permission for _____ to go out supervised for alcoholic drinks. Allowed a maximum of _____ drinks.

DATE: _____ SIGNATURE: _____

PRIVACY CONSENT :

I consent for Belwood Lodge and Camp to obtain and use all personal information for the purposes of providing care, financial transactions and for direct mailings. Information will be retained for 10 years and then discarded.

DATE: _____ SIGNATURE: _____

STUDENTS/VOLUNTEERS:

I hereby grant permission for placement/co-op students and volunteers to assist with camper/lodger's programming and daily care.

DATE: _____ SIGNATURE: _____

MEDICATIONS

- *all medications must be listed on the below chart
- *all medications must be doctor prescribed
- * must be in pharmacy dispensed **MULTI BLISTER PACKAGES**
- *must follow what is written on pharmacy label
- *do not send unneeded medications (vitamins/treatments/creams)
- *all medications are administered by health centre staff
- *list treatments also if required during stay
- * mar sheets are not accepted
- * only medications which follow the above rules will be administered
- *camp has own supply of PRN standing order medications
- *NO EXCEPTIONS MADE TO THE ABOVE RULES

Please fill in the below chart by writing in the name of all medications, the dosage of each pill, and under the times available write down the number of pills to be administered. These are the only medication times available.

MEDICATION TREATMENT	MG OF EACH PILL	8 AM	12 PM	5 PM	9 PM	PRN

MUST BE FILLED OUT:

Name of person who has completed this form: _____

Signature of above person: _____

Date: _____ Phone No.: (_____) _____