



CAMP HEMLOCKS

85 Jones Street, Amston, CT 06231

Phone: 860.228.0393 ext. 4068

E-mail: Jillian.McCarthy@oakhillct.org | Fax: 860.228.0401



CAMPER INFORMATION

Camper Name: _____ Date: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____ *City State ZIP Code*

Phone: _____ Email: _____

NAME OF LEGAL GUARDIAN (IF CAMPER IS NOT THEIR OWN LEGAL GUARDIAN)

Name: _____ Relationship to camper: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____ *City State ZIP Code*

Phone: _____ Email: _____

Do you plan on being away while your camper is at camp? YES NO If so, will we be able to reach you at the phone number above? YES NO

Please feel free to include itinerary information or alternate phone numbers here: _____

If we are unable to reach you please list those we may contact in case of an emergency (below).

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
 Home Phone: _____
 Cell Phone: _____

Name: _____ Relationship: _____
 Home Phone: _____
 Cell Phone: _____

Assistive Technology Camp Information

DORS LEVEL UP COUNSELOR INFO (TO BE COMPLETED BY GUARDIAN)

Level Up Counselor Name: _____ Phone: _____

E-mail: _____

CAMPER INFO (TO BE COMPLETED BY GUARDIAN AND CAMPER)

What do you believe are the camper's major strengths in the following environments:

In school/academics? _____

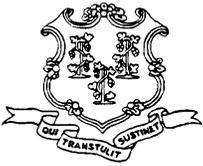
At home/community? _____

In work setting? _____

What is the camper looking to get out of this experience? Please list and explain in order according to priority (1 – highest priority).

- 1. _____
- 2. _____
- 3. _____

What is the camper's current use of technology? Please list any and all technology tools that the student has access to and can use successfully. Please include traditional technology as well as assistive technologies.



DORS Level UP AT Camp 2016

STATE OF CONNECTICUT DEPARTMENT OF REHABILITATION SERVICES

Bureau of Rehabilitation Services Testimonial Release

I hereby agree as follows:

1. I give and grant to the Bureau of Rehabilitation Services, its respective licensees, successors and assigns (herein collectively called the "licensed parties"), the right to use, publish and copyright my name, voice, picture, portrait and likeness in all media and types of advertising and promotion of the Bureau of Rehabilitation Services.
2. I agree all photographs, audio or video of me used and taken by the licensed parties are owned by them and that they may copyright material containing same. If I should receive any print, negative or other copy thereof, I shall not authorize its use by anyone else.
3. I agree that no advertisement or other material need be submitted to me for any further approval and the licensed parties shall be without liability to me for any distortion or illusionary effect resulting from the publication of my picture, portrait or likeness.
4. I warrant and represent that this license does not in any way conflict with any existing commitment on my part. I have not heretofore authorized (which authority is still in effect), nor will I authorize or permit the use of my name, picture, portrait, likeness or testimonial statement in connection with the advertising or promotion of any product or service competitive to or incompatible with the Bureau of Rehabilitation Services.
5. I further agree that the licensed parties will have the right to attribute the attached statement (or statements in different words which have substantially the same meaning) to me, which is an expression of my personal experience and belief.
6. Nothing herein will constitute any obligation on the licensed parties to make any use of any of the rights set forth herein.

Consumer Print _____

Consumer Signature _____

Legal Guardian Print _____

Legal Guardian Signature _____

Date _____

Revised effective 10/31/14

Bureau of Rehabilitation Services

55 Farmington Avenue • 12TH FLOOR, HARTFORD, CT 06105

Phone: (860) 424-4844

Information: 1-800-537-2549 TDD: (860) 424-4839

Fax: (860) 424-4850

An Equal Opportunity / Affirmative Action Employer

This section provides us with information to properly prepare for your camper’s arrival and ensures s/he has the best experience possible.

MOBILITY

- Fully independent with ambulation
- Needs assistance with ambulation
- Uses a manual wheelchair independently
- Uses a manual wheelchair with assistance
- Uses an electric wheelchair
- Needs assistance with transfers
- Uses adaptive equipment (walker, crutches, braces, etc...)
Please list:

COMMUNICATION

- Speaks clearly
- Uses a communication device
- Uses hands more than speech
- Uses facial expressions to respond
- Uses modified sign language
- Requires large print materials
- Listening: has difficulty understanding communication of other people
- Receptive Language: has difficulty comprehending spoken and written language
- Expressive Language: has difficulty in using both spoken and written language to communicate with others

ACTIVITIES OF DAILY LIVING

	Independent/ No Assistance	Verbal Prompts/ Minimal Assistance	Modeling/ Partial Assistance	Hand over Hand/ Total Assistance
Dressing (buttoning, zippering)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Showering (Shampooing/ washing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting (wiping, hand washing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night Turns (If applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer to Bed (If applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer to Toilet (If applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DIETARY INFORMATION

- | | |
|---|--|
| <input type="checkbox"/> Feeds self independently | <input type="checkbox"/> Needs assistance with cutting up food |
| <input type="checkbox"/> Needs assistance to eat | <input type="checkbox"/> Uses a straw to drink |
| <input type="checkbox"/> Has doctor's orders for a cut, chopped, ground or puréed meal and/ or thickened food/ liquids (Please attach a copy) | <input type="checkbox"/> Requires limited portions (**please describe below) |
| <input type="checkbox"/> Uses special utensils, cup or plate (**Please describe below) | |

Has food allergies**

(please describe below what type of reaction is associated with each allergy [Hives, GI upset, Anaphylaxis])

Has a special diet** (please include details below)

Appetite is usually: Excellent average fair poor Time typically required for meals:

Please use this space to provide details for those checked above marked

PERMISSIONS

I give permission for the above named camper to attend Easter Seals Camp Hemlocks and participate in all phases of the program (except those indicated as medically contradictory by the camper's physician) both on and off the camp property. In addition, I consent to, the release of camper evaluations, medical examination records, and personal data and records deemed necessary by the Camp Director. I acknowledge that the Camp Director reserves the right to send a camper home if illness, behavior or other significant reason so dictates and that there is a no refund policy. I give permission for a camp representative to contact those I have listed, in the event of an emergency and I cannot be reached. I acknowledge all emergency contacts have consented and have permission to care for the above named camper.

Signature of legal guardian: _____ Print: _____ Date: _____

I give permission for photographs and video of the above named camper to be used in the public relations program of Easter Seals Camp Hemlocks.

Signature of legal guardian: _____ Print: _____ Date: _____



CAMP HEMLOCKS

85 Jones Street, Amston, CT 06231

Phone: 860.228.0393 ext. 4068

E-mail: Jillian.McCarthy@oakhillct.org | Fax: 860.228.0401



EMERGENCY CONTACT INFORMATION

Camper Name: _____ Date of Birth: _____

Address: _____

Street Address

Apartment/Unit #

City

State

ZIP Code

Phone: _____ Email: _____

Parent/ Guardian: _____ Phone: _____

Emergency Contact #1: _____ Relationship: _____

Cell Phone: _____ Work or Home Phone: _____

Emergency Contact #2: _____ Relationship: _____

Cell Phone: _____ Work or Home Phone: _____

VACCINATION HISTORY

Vaccine	Original immunization date (Month/ Year)	Most recent booster date (Month/ Year)
Tetanus		
Diphtheria		
Pertussis		
Mumps		
Measles		
Rubella		
Polio		
Chicken Pox		
Hepatitis B		
HIB- haemophilus influenza b		
PCP- Pneumococcal Conjugate		

MEDICAL HISTORY

Please check yes or no. Explain yes answers below.

	Yes	No		Yes	No		Yes	No
Frequent Ear Infections			Recent illness or infectious disease			Bleeding/ Clotting Disorder		
Seizure Disorder			Hospitalization			Surgery		
Heart Disease			History of bed-wetting			Diabetes		
Insect Stings			Eating Disorder			Sleepwalking		
Hay Fever			Emotional Disorder			Diarrhea/ Constipation		
Poison Ivy			Breathing problems/ Asthma			Abnormal menstruation		
Chronic Illness			Dietary Restrictions			Food Allergies		

If yes, please explain here: _____

MEDICAL INSURANCE

Medical Insurance Carrier: _____ Policy Number: _____

Secondary Insurance Carrier: _____ Policy Number: _____

(* A photocopied copy of insurance card front & back must be attached to this form.)

IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE

This health history is correct as of the date noted so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as may be noted on the physical examination form. I, as parent, guardian, caretaker, or adult camper am responsible for any changes or updates to medical condition, medications, and restrictions added or removed between the dates of this paper and the beginning of camp.

Signature of Legal Guardian_____
Date

I also understand and agree to abide with the restrictions placed on camp activities.

Signature of Legal Guardian_____
Date

Emergency Authorization: I hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine test and treatments for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia and/or surgery for me/ or my dependent/ward as named above. I agree to the release of any records necessary for treatment, billing, referral, or insurance purposes.

Signature of Legal Guardian_____
Date



CAMP HEMLOCKS

85 Jones Street, Amston, CT 06231

Phone: 860.228.0393 ext. 4068

E-mail: Jillian.McCarthy@oakhillct.org | Fax: 860.228.0401



PHYSICAL EXAMINATION RECORD

DATE OF EXAM: _____

Both front and back must be completed by a physician, signed off by the legal guardian and dated within 12 months of the campers first day at camp.

Camper Name: _____ Date: _____

Height: _____ Weight: _____ Blood Pressure: _____

Diagnosis(s): _____

Current Treatment(s): Please indicate if any will need to be provided while at camp _____

Does the camper have known food or drug allergies? YES NO If Yes, Please explain/describe and note severity of reaction: _____

Does the camper have a seizure disorder? YES NO If yes, average occurrence? _____

Please describe this camper's typical seizure including any known auras: _____

If no, has this camper EVER had a seizure? YES NO If yes, when/ what was the cause? (Ex, Infancy, high fever) _____

DO NOT ADMINISTER TO THIS CAMPER: Please indicate what medications cannot be administered while at camp by drawing a single line through all that apply.

Medication	Medication	Medication
<i>Example: Acetaminophen</i>	Milk of Magnesia, laxative	A&D ointment, skin relief
Acetaminophen, pain reliever/ fever reducer	Dulcolax, laxative	Hydrocortisone 1% cream, skin relief
Ibuprofen, pain reliever/ fever reducer	Dextromethorphan, cold relief	Calamine lotion, Skin relief
Mylanta, antacid	Throat lozenges, throat relief	Aloe, sun burn relief
Tums, antacid	Pseudoephedrine, decongestant	Bengay, muscle pain relief
Pepto-Bismol, stomach relief	Guaifenesin, cough suppressant	Bacitracin, minor cuts/ scrapes
Diphenhydramine, allergy relief	Dramamine, motion sickness	Tinactin/ Lotrimin, antifungal

This camper may participate in all camp activities including but not limited to, swimming, boating, ropes course, and climbing tower.

This camper may participate with the following restrictions: (Example- Must wear lifejacket to swim, or can participate in swimming and boating but no ropes or climbing) _____

Print name of Physician: _____ Telephone: _____

Practice Name: _____ City: _____ State: _____ Zip Code: _____

Signature of Physician

Date Signed

