

# Children's SEEK Camper Profile

**Bridgeport Camp & Conference Center  
North Texas Conference of the United Methodist Church**

*This form is provided to camp counselors as background information for working with your Camper.*

**If returning **by mail**,  
please attach a recent  
photo of Camper.**

**If **emailing** application,  
please attach photo to  
email.**

Camper Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender M / F \_\_\_\_\_

Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

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

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ His Wk Phone \_\_\_\_\_ His Cell \_\_\_\_\_

Her Wk. Phone \_\_\_\_\_ Her Cell \_\_\_\_\_

Best Contact Email \_\_\_\_\_

Emergency Contact (other than parent) \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Wk Phone \_\_\_\_\_ Cell \_\_\_\_\_

Names and ages of family members: \_\_\_\_\_  
\_\_\_\_\_

Primary Diagnosis (please describe): \_\_\_\_\_  
\_\_\_\_\_

How does Camper Communicate? \_\_\_\_\_

Describe Camper's Motor Skills: \_\_\_\_\_  
\_\_\_\_\_

Can Camper: Button? \_\_\_\_\_ Lace? \_\_\_\_\_ Tie? \_\_\_\_\_ Comb hair? \_\_\_\_\_ Shampoo? \_\_\_\_\_ Undress? \_\_\_\_\_

Does Camper need assistance getting around? \_\_\_\_\_ What kind? \_\_\_\_\_

Has your Camper ever been away from home alone? Yes / No \_\_\_\_\_

Has your Camper ever been to camp? Yes / No \_\_\_\_\_  
Campers favorite activities? \_\_\_\_\_

What are activities that your Camper does not like or is afraid of? \_\_\_\_\_

How does your camper get along with adults? \_\_\_\_\_

How does your Camper get along with other children/youth? \_\_\_\_\_

Are there behavior problems or concerns that you have specific ways of handling? Would you like for us to continue this?  
We ask because we feel that being consistent in our expectations of the Camper is only fair.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SELF CARE:**

Can Camper shower? \_\_\_\_\_ Can Camper shower self alone? \_\_\_\_\_

Needs supervision only \_\_\_\_\_ Must be bathed? \_\_\_\_\_

Any special props or devices needed for Camper in the shower? \_\_\_\_\_

Can Camper brush teeth? \_\_\_\_\_ Needs assistance/directions? \_\_\_\_\_

Is Camper completely toilet trained? \_\_\_\_\_ Can go alone? \_\_\_\_\_

Wipes self? \_\_\_\_\_ Needs supervision? \_\_\_\_\_ Self-catheterization? \_\_\_\_\_

Needs catheterization help? \_\_\_\_\_ Any specific instructions? \_\_\_\_\_

Words or signs that Camper uses to indicate toilet needs? \_\_\_\_\_

**EATING HABITS:**

Needs NO help \_\_\_\_\_ Needs some help \_\_\_\_\_ Needs much help \_\_\_\_\_

Instruction if help is needed (please explain in detail): \_\_\_\_\_

Left or Right handed? \_\_\_\_\_

Additional information (please describe how you handle any special eating problems): \_\_\_\_\_

Chokes easily? \_\_\_\_\_ Chews well? \_\_\_\_\_ Not well? \_\_\_\_\_ Other \_\_\_\_\_

Can Camper wash hands before meals? \_\_\_\_\_ Needs help? \_\_\_\_\_

Specific foods Camper likes? \_\_\_\_\_

Specific foods Camper dislikes? \_\_\_\_\_

**DRESSING HABITS:**

Can camper dress self? \_\_\_\_\_ Appropriately selects clothes? \_\_\_\_\_

Needs supervision? \_\_\_\_\_ With what? \_\_\_\_\_

**FEMALE CAMPERS ONLY:**

Care during menstrual periods:

Has Camper begun menstrual periods? \_\_\_\_\_ Can Camper manage without help? \_\_\_\_\_

Needs supervision? \_\_\_\_\_ Needs help? \_\_\_\_\_ Exactly what help? \_\_\_\_\_

\_\_\_\_\_

Is there anything else that you would like us to know about your Camper that could help us make his/her experience even more enjoyable?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there a person you'd like your camper to room with? We will take your request in consideration, but please understand that we are not always able to accommodate this request. \_\_\_\_\_

**T-SHIRT**

Each camper will receive a camp t-shirt at camp. Please indicate what size shirt your camper will need.

Children's Sizes: 10 -12 \_\_\_\_\_

14 -16 \_\_\_\_\_

Adult Sizes: Small \_\_\_\_\_

Medium \_\_\_\_\_

Large \_\_\_\_\_

X-Lg \_\_\_\_\_

XX-Lg \_\_\_\_\_

XXX-Lg \_\_\_\_\_

**DVD**

We will have a DVD of this year's SEEK Camp. The cost of the DVD is included in the price of camp. The DVD will be mailed to you sometime after camp is over. The DVD is a great way for your Camper to remember and relive the great time had at SEEK Camp!

Please complete ALL 9 pages of this application and do not forget to attach:

- Photo of Camper
- Copy of Immunization Records
- Notarized Medical Release Form
- Medical Release from Doctor or NP

**MAIL Application & Forms to:**

or

**EMAIL Application & Forms to:**

Children's SEEK  
Chaney Cheatham  
17406 FM 678  
Whitesboro, TX 76273

childrensseekcamp@yahoo.com

*This page must be notarized*

# Medical Release/Consent

Camper Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Camper SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender M / F Age \_\_\_\_\_

The undersigned acknowledges and understands that the above named camper's ("Camper") participation in the Camp Program and related recreational activities may involve risks to the Camper's physical well-being. With full knowledge of said risks and in consideration of the benefits derived by the Camper in the participation of the camp and programs, I hereby consent, approve, covenant and agree to indemnify and save harmless Bridgeport Camp & Conference Center and the North Texas Conference of the United Methodist Church, their agents, servants, employees, representatives, volunteers and staff from and against all actions or causes of action, claims, demands, liabilities, loss, or damage to the Camper resulting or arising out of the Camper's attendance at the Camp or participation in any Camp related activity of any kind, including, without limitation, any cause of action sounding in negligence.

In the event I cannot be reached in a medical emergency, I hereby give my consent and authorization for medical treatment by a health care professional for the purpose of preserving the life and/or well being of the above named Camper.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Circle: Parent / Guardian / Managing Conservator of Minor Child

THE STATE OF TEXAS

COUNTY OF \_\_\_\_\_

BEFORE ME, the undersigned authority, on this day personally appeared \_\_\_\_\_,  
Known to me to be the person whose name is subscribed to the above Medical Release/Consent and acknowledge to me that he/she executed the same for the purposes and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public, State of Texas

Application Deadline: March 30, 2017

NAME: \_\_\_\_\_

Attach a copy of Immunization Record and copy of your Insurance Card to Camp Form

## SEEK Camp Medical Form

Camper Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Camper SS# \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Gender M / F Age \_\_\_\_\_

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

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ His Wk Phone \_\_\_\_\_ His Cell \_\_\_\_\_

Her Wk. Phone \_\_\_\_\_ Her Cell \_\_\_\_\_

Emergency Contact (other than parent) \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Wk Phone \_\_\_\_\_ Cell \_\_\_\_\_

Physician Name \_\_\_\_\_ Office Phone \_\_\_\_\_

Dentist Name \_\_\_\_\_ Office Phone \_\_\_\_\_

Orthodontist Name \_\_\_\_\_ Office Phone \_\_\_\_\_

Insurance Carrier/Plan Name \_\_\_\_\_ Group # \_\_\_\_\_

Policy # \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

SS # of Policy Holder \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Adequate disclosure of health history is crucial in providing the best care to your child. We want to provide a supportive, safe, and healthy camp environment to all campers and staff.

**ALLERGIES – List all known:**

Medical Allergies	_____	Reaction & Treatment	_____
	_____		_____
	_____		_____
Food Allergies	_____	Reaction & Treatment	_____
	_____		_____
	_____		_____
Other Allergies	_____	Reaction & Treatment	_____
	_____		_____
	_____		_____

**GENERAL HISTORY – Mark the appropriate response for each statement:**

Yes\_\_ / No\_\_ This Camper has had chicken pox or varicella vaccination.

Yes\_\_ / No\_\_ This Camper has had mononucleosis in the past 12 months.

Yes\_\_ / No\_\_ This Camper has a history of illness, injury, or surgery which will affect participation.

If yes, please explain: \_\_\_\_\_

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**Chronic Concerns – Check all that apply to your camper and provide any helpful information for care.**

This Camper has NO chronic health concerns and is capable of full participation at camp.

This Camper has the following health concern(s):

\_\_\_ Asthma (even if inhaler is only used occasionally) \_\_\_\_\_

\_\_\_ Frequent ear infections \_\_\_\_\_

\_\_\_ Migraine headaches \_\_\_\_\_

\_\_\_ Enuresis (bed-wetting) \_\_\_\_\_

\_\_\_ Depression, ADD, ADHD, Oppositional Behavior Disorder \_\_\_\_\_

\_\_\_ Anorexia, Bulimia (eating disorders) \_\_\_\_\_

\_\_\_ Diabetes \_\_\_\_\_

\_\_\_ Seizures, If so, please describe \_\_\_\_\_

\_\_\_ Any other chronic illness? \_\_\_\_\_

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**Supportive Care – Check all that apply to your camper and provide any helpful information for care.**

This Camper has the following health concern(s):

\_\_\_ Glasses \_\_\_ Hearing Aid(s) \_\_\_ Wheelchair \_\_\_ Walker \_\_\_ Communication Device \_\_\_ Dental Appliances

\_\_\_ Braces If so, can braces be removed? \_\_\_\_\_ If so, for how long? \_\_\_\_\_

\_\_\_ Catheterized If so, how often? \_\_\_\_\_ Can Camper do this? \_\_\_\_\_

\_\_\_ Other special equipment \_\_\_\_\_

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**Diet** – Please note that camp is not equipped to prepare special diets for campers. If your camper has special dietary needs, please notify the camp director in advance of your camper’s arrival to camp. Some dietary restrictions can be accommodated; however, these must be addressed prior to camp.

**Special Needs** – Are there any special concerns that you have as a parent or guardian regarding the medical and health needs of your child while at SEEK Camp? If so, please explain below in detail:

**MEDICATIONS:**

- This Camper does not take any medications on a regular basis.
- This camper takes routine medications

Bring enough to last all week. **Please sort and label all medications for each day and time.**

Please list all prescription medication, over-the-counter, and non-prescription drugs taken regularly.  
Fill in all blanks completely.

Medication	Reason	Dose	When it is taken
1.			
2.			
3.			
4.			
5.			
7.			
8.			
9.			
10.			

## SEEK Camp

### Parent Authorization to Administer Medication

Camper Name: \_\_\_\_\_

SEEK camp personnel must have written parental consent in order to administer over-the counter medication (OTC). Generic equivalents maintained by the nurse may be used in place of brand name. OTC medications will be administered sparingly and according to standardized dosing instruction when indicated to make your child more comfortable.

Please check off the medication that you give permission for your child to receive and **CROSS OUT** any that should not be given:

Pain reliever / Fever reducer

- Acetaminophen (generic Tylenol)
- Ibuprofen (generic Motrin or Advil)

Constipation / Diarrhea

- Milk of Magnesia
- Immodium

Cold / Congestion / Allergy

- Diphenhydramine (generic Benadryl)
- Robitussin DM
- Cough Drops
- Chloroseptic Spray

Skin

- Calamine Lotion
- Hydrocortisone Cream
- Neosporin Ointment
- Sunburn lotion

Antiseptics

- Rubbing Alcohol
- Hydrogen Peroxide

Eye Wash

- Saline Eye Wash

Indigestion

- Tums
- Pepto Bismol

I hereby authorize the nurse to administer medication designated on this form in accordance to standardized dosing instructions. I understand that any nurse who administers these medications according to proper dosages shall not be held liable for damages as a result of an adverse reaction to the medications administered.

Parent/guardian \_\_\_\_\_

Date \_\_\_\_\_



Application Deadline: March 30, 2017

NAME: \_\_\_\_\_

I **DO NOT** want any of the above medications given to my child at camp.

*This page must be completed by a licensed Physician or Nurse Practitioner and can be based on an examination within the past year prior to the Camper's session at camp.*

## MEDICAL RECOMMENDATION:

Camper Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Camper SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender M / F Age \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

This camper is under the care of a physician, or has been in the past, for the following: \_\_\_\_\_

\_\_\_\_\_

Treatment to be continued at SEEK Camp for this Camper: \_\_\_\_\_

\_\_\_\_\_

Routine medications that this Camper will be on while attending SEEK Camp are: \_\_\_\_\_

\_\_\_\_\_

Camper is allergic to the following: \_\_\_\_\_

Treatment for allergic response: \_\_\_\_\_

List any restriction that this Camper should have at SEEK Camp and describe the limitations:

\_\_\_\_\_

Additional health information needed for a successful experience at SEEK Camp: \_\_\_\_\_

\_\_\_\_\_

MD/NP Signature \_\_\_\_\_

Date \_\_\_\_\_

MD/NP Name \_\_\_\_\_

Office Phone \_\_\_\_\_

Address \_\_\_\_\_

Application Deadline: March 30, 2017

NAME: \_\_\_\_\_