Application Deadline: JULY 1, 2017 NAME:______________________________

Youth 2

SEEK Camper Profile

Prothro Center at Lake Texoma
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:**

Youth 2 SEEK
Donny Haywood
206 Grayson St.
Nocona, TX 76255

thepastordonny@gmail.com

Application Deadline: JULY 1, 2017 NAME:___________________________________

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: JULY 1, 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 # __________________________________

Application Deadline: JULY 1, 2017 NAME:______________________________

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: ____
____

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? ____
____

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 ____
____

NAME:________________________________

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 will in advanced 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:

- o This Camper does not take any medications on a regular basis.
- o 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____________________

☐ 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 ________________________________