

Youth 2 SEEK Camper Profile

Prothro Center at Lake Texoma
North Texas Conference of the United Methodist Church
July 1st – 5th, 2019

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): _____

School attending/graduated from: _____

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 Camper ever been to SEEK Camp? *Yes / No* _____

Attend/attending other camp(s)? *Please list:* _____

Camper's 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? _____

SLEEP HABITS: Does Camper sleep? _____

Does Camper sleep w/ bed rails? _____ Can Camper sleep on top bunk? _____

List helpful bedtime routine info: _____

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 _____

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

EMAIL Application & Forms to:
thepastordonny@gmail.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: May 31, 2019

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: _____

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 _____

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:

- 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

I **DO NOT** want any over-the-counter medications given to my child at camp.

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 _____

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 _____