

**Camp Abilities
6714 Scanlan Ave.
St. Louis, Mo. 63139
(314) 873-9022
July 9-14, 2017**

Camper Eligibility

Please read carefully before registering your child for Camp Abilities. The following is a list of eligibility criteria for each camper attending Camp Abilities St. Louis. Any child that is removed from the program due to violations will have to be picked up at the parents' expense.

Children who attend Camp Abilities St. Louis must possess the following in order to participate:

- are between the ages 10 to 16 years of age;
- have a visual impairment (must have a vision teacher);
- are predominately independent (helping with tying shoes, bathing, toileting, or picking clothes ok);
- possess verbal skills appropriate within two years of their age;
- display behaviors that will allow them to function in group setting that does not affect other group members (no biting, kicking, displays of defiant behavior, or running away);
- do not possess medical problems that require a nurse's constant supervision.

Parents must disclose all necessary information that allows us to provide a safe environment for their child's week at Camp Abilities-St. Louis.

Any child that is removed from the program due to violations will have to be picked up at the parent's expense.

Athletes will be ineligible, and will be sent home at the parent's expense if they display the following:

- running away from the facility;
- displaying biting, scratching, or hitting behaviors;
- communicable diseases or medical needs that require constant nursing supervision;
- defiant behavior or conduct disorders;
- mobility limitations that prohibit them from participating in sports activities.

We, the administrative staff of Camp Abilities St. Louis, have the power to send your child home at your expense if the conditions of camp eligibility are not met.

I have read, understand, and will abide by these eligibility standards

Signature: _____

Date _____

CAMPER INFORMATION SHEET

Dear Camper:

In order to give you the very best time at camp, we would like to get to know you - even before we meet you! Please take the time to complete the following information for your counselor.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____

Do you read: Braille? Yes No Large Print: Yes No

Regular print: Yes No

Have you ever been to an overnight camp? Yes No

If yes, When? _____

What school do you attend? _____

Your grade level: _____

What are your favorite subjects? _____

Do you have a nickname? _____

Do you have any hobbies? _____

What are your favorite sports? _____

Do you have a friend attending Camp Abilities St. Louis? Yes No

Who? _____

Do you know how to swim? Yes No

Do you like boat rides? Yes No

What are your favorite crafts? _____

What is your favorite outdoor or nature activity? _____

What is your favorite food? _____

What musical instrument(s) do you play? _____

Do you have any brothers? ____ Sisters? ____ How old? _____

Do you have any pets? What are they and what are their names: _____

Do you have any concerns about your week at camp? _____

T-shirt size: _____

CAMPER MEDICAL INFORMATION

Name: _____ DOB: _____ Age: _____

Male: Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

EMERGENCY CONTACT

In case of emergency please notify:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Secondary contact:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

INSURANCE INFORMATION

Please submit copy of insurance card Insurance information:

Carrier # _____ Group# _____

Primary name on card: _____

Physician's Name: _____

Phone: _____

PERSONAL HEALTH HISTORY:

Indicate if you have ever had or currently have the following diseases or conditions. All information is confidential; you must complete this form. Make a check in the appropriate box to answer.

ALLERGY to Medicine/Food/other No Yes If "yes," please explain:

Anxiety No Yes If "yes," please explain:

Asthma No Yes If "yes," please explain:

Bone or Joint Disorder No Yes If "yes," please explain:

Cancer No Yes If "yes," please explain:

Chicken Pox (Varicella) No Yes If "yes," please explain:

Depression/Suicide/Eating Disorder
or other Mental Health Diagnosis

No Yes

If "yes," please explain:

Diabetes

No Yes

If "yes," please explain:

Dizziness

No Yes

If "yes," please explain:

Ear Disease or Hearing Loss

No Yes

If "yes," please explain:

Eye Disease

No Yes

If "yes," please explain:

Head Injury or Concussion

No Yes

If "yes," please explain:

Headaches (Indicate medications used) No Yes If "yes," explain:

Heart Murmur or Disease

No Yes

If "yes," please explain:

Insomnia/sleep difficulty

No Yes

If "yes," please explain:

Kidney or Bladder Infections

No Yes

If "yes," please explain:

Seizures (Indicate type, frequency and medications used) No Yes

If "yes," please explain: _____

Tuberculosis

No Yes

If "yes," please explain:

Unusual Shortness of Breath
when exercising

No Yes

If "yes," please explain:

Use a mobility device cane, walker self-
propelled wheelchair electric wheelchair

No Yes

If "yes," please explain:

Other health concerns: _____

Immunization Record (attach document if available)

1st MMR (Measles/Rubeola, Mumps, Rubella)

(Must be 12 months old or older for 1st dose)

#1 MMR _____ / _____ / _____

2nd MMR (MUST be 30 days or more following 1st dose)

#2 MMR _____ / _____ / _____

Tdap Adacel/Boostrix - Tetanus/Diphtheria acellular Pertussis or

Tdap _____ / _____ / _____

TETANUS/DIPHTHERIA Td _____ / _____ / _____

VARICELLA (Chicken Pox) –

Disease No Yes If yes, when _____ / _____ / _____
or Vaccine Dates: #1 _____ / _____ / _____ #2 _____ / _____ / _____

RELEASE TO TREAT

I give my permission to Camp Abilities or other trained medical staff to care for the above named camper _____ in my absence should a medical emergency occur. I also give permission the Camp Abilities or other trained medical staff to provide simple care such as over the counter pain reliever, antibiotic ointment in the event of minor illness or injury. I have indicated his/her allergies.

Parent or Guardian signature

Date

Print Name _____ Phone: _____

Coach/Volunteer signature

Date

Print Name _____ Phone: _____

Camp Abilities Medication Administration & Authorization Form

Camper Name _____ Date of Birth _____

If a camper needs to take medications during their time at Camp Abilities, we have trained and certified medication administration personnel to facilitate this. To adhere to the associated regulations, any medications including vitamins, supplements, and homeopathic remedies must be accompanied by direct authorization from a physician. The camper's physician must complete this form in its entirety or provide us with a medical authorization form for each medication the camper will need to take while at camp.

All medications MUST:

- Be in original packaging (i.e. labeled prescription vials)
- Have authorization from a physician (the form below)
- Be administered by trained and certified medication administration personnel. Under no circumstances should a camper carry or self-administer and medication (with the exception of campers allowed to self-carry inhalers).

Please attach action plans for any serious medical issues (EPI pens, seizures, Diabetes, inhalers, etc)

Physician's Signature: _____

Printed Name: _____ Date: _____

Office Name: _____

Email: _____ Phone: _____

Address: _____

Medication	Dose	Schedule and other Details

Additional Instructions: _____

CAMPER WAIVER OF LIABILITY AND PHOTO RELEASE

I, _____ give my consent for my child _____ to participate in Camp Abilities-St. Louis. I will not hold Missouri School for the Blind, St. Louis Lighthouse for the Blind, or MOUSABA (Missouri Chapter, United States Association for Blind Athletes) responsible in case of accident or injury, including death, whether it be in route to camp activities, during camp activities, or while on MSB's campus. I hereby agree to hold the organizations, camp officers, coaches, volunteers, agents or employee's Harmless from any and all liabilities, actions, debts, claims or demands of any kind and nature whatsoever that may arise by or in connection with participation by me, or my child in any activities of the camp. I hereby consent to any publicity, including the use of my Name _____ or my child's name _____ and likeness in connection with participation in Camp Abilities-St. Louis.

Parent Signature

Date

Coaches/Volunteer Signature

Date