



Camper Application

Application Checklist:

- Carefully read through the requirements for admission to camp to determine eligibility.
- Complete the identifying information, insurance, and personal history sections of the application in full. Be sure to attach a copy of your insurance card.
- Read and sign the waiver of liability, photo release, and fee agreement forms.
- Take the medical information form to your doctor to complete. Please note that all campers are required to undergo a physical examination no sooner than three months prior to attending camp. (Physicals completed before April 29, 2007 will not be accepted).
- Mail the entire application with your \$25 non-refundable deposit to:
Association for Individual Development
Attn: Camp Forever
409 W. New Indian Trail Court
Aurora, IL 60506

Additional information and forms may be found on our web site: www.the-association.org or by calling AID at 630-966-4252.

Criteria for Admission to AID's Camp Forever 2007

REQUIREMENTS:

1. The applicant must be mentally aware that they are participating in a camping program and be capable of responding to camp counselors with either a verbal, audible or physical response such as eye movement, gestures, etc.
2. The applicant must be able to adapt to the group living routine of camp without detracting from group living environment including, but not limiting to: sleeping without bothering other campers, following directions given by counselors & program leaders, & enjoying meals in the dining hall.
3. The applicant must be accepted based on qualifications & availability of staff.
4. The applicant must provide all required medical information to determine the suitability of the camper's admission to camp. The Camp Nurse will review all health issues to discern eligibility.
5. Conditional acceptance may be made for new applicants for their first year of attendance.
6. The applicant **cannot** be abusive to him/herself or others.

APPLICANTS WHO DON'T MEET ELIGIBILITY REQUIREMENTS FOR CAMP:

1. Applicants with a medical condition that requires specialized medical treatment, (such as intravenous infusions), that the camp is not capable of or can not reasonably provide.
2. Applicant with medical conditions at high risk for complication or injury such as extreme respiratory problems, surgical or injury recovery, predilection for orthopedic complication.
3. History of physical abuse of self or others including hitting, biting, scratching, spitting, kicking, etc.
4. History of verbal abuse that would disrupt camp programs & routines.
5. History of behavioral problems that would disrupt camp programs & routines.
6. History of inappropriate sexual behavior.

APPLICANTS WILL NOT BE ADMITTED TO CAMP if their health in any way endangers other campers & staff or if there is a problem requiring the attention of a physician. Such conditions could be defined as, but are not limited to the following:

1. Oral temperature greater than 100.4°
2. Blood pressure greater than 160/90
3. Heart rate greater than 120 BPM
4. An open, draining sore
5. Topical parasites such as lice, scabies
6. Campers with alteration in vital signs indicating deferral of admission will be observed closely for one hour in the infirmary prior to re-evaluation.
7. The Camp Director will be consulted & his/her approval obtained prior to any deferral.

APPLICANTS WHO EXHIBIT BEHAVIOR/CONDITIONS following their arrival may necessitate deferral of admission. Such circumstances include, but are not limited to:

1. Behaviors outlined previously in this booklet.
2. Exacerbation of medical conditions, signs of infection or communicable disease.
3. Inability or refusal to eat or drink enough to insure proper nutrition.
4. Inability or refusal to take prescription medication.

The Camp Director reserves the right to accept or deny applications on-site or prior to attendance & will be the party responsible for acceptance or denial.

2007 CAMP FOREVER APPLICATION

MUST BE FULLY COMPLETED BEFORE CAMPER IS CONFIRMED.

Mail to: Camp Forever, 409 West New Indian Trail Court, Aurora, IL 60506

Phone: (630) 966-4254

Camp Forever is a program of the Association for Individual Development. This information is required for Camp Forever's use only in helping to make the applicant's camp experience positive and more enjoyable and will be held in the strictest confidence.

PLEASE PRINT OR TYPE

IDENTIFYING INFORMATION

Social Security Number: _____ Date of Birth: _____

Last Name First Name Middle Name Name Called Sex Age Race

County Camper's Address

City State Zip Home Phone Email

Custody Status (Please circle one): Parent Guardian Ward of the State

Mother's Name Address City State Day Phone Night Phone

Father's Name Address City State Day Phone Night Phone

Guardian's Name Address City State Day Phone Night Phone

Father's place of employment _____ Mother's place of employment _____

Emergency Contact other than above – Name _____ Relationship _____

Phone #s _____

Has camper attended Camp Forever before? Yes No When? _____

How did camper find out about Camp Forever? _____

INSURANCE INFORMATION

Please attach a copy of your insurance card.

Insurance Coverage for accidents or illnesses while participating in programs at Camp Forever is the responsibility of the camper's family. Please list your family health, accident, medical, or hospital insurance coverage.

Carrier: _____ Policy or Group No: _____ Medicaid No: _____

The Camp Director reserves the right to send the camper home if illness or other significant reason so dictates. If above named camper must be sent home and I cannot be reached, the following person has consented and has permission to care for the camper:

Name _____ Phone(s) _____

Address _____

City _____ State _____ Zip _____

Every effort will be made by telephone to immediately notify parent or guardian of a camper's illness, injury, accident, or behavior problem; hence the importance of providing the camp staff with phone numbers of your whereabouts during the camp session or a responsible party in your absence.

Signature of Parent/Guardian

Date

MEDICAL INFORMATION—EVERY BLANK MUST BE COMPLETED

Medical Diagnosis: _____

Birth Date: _____ **Mental Age/Ability:** _____ **Functional Age:** _____ **Height:** _____ **Weight:** _____

Onset Date _____ **Cause of Disability** _____

Seizures? (circle one) Yes No **Type** _____ **Frequency** _____

Recovery Time _____ **Treatment** _____

Has camper had any recent hospitalizations or illnesses (within the past year)? Yes No

If yes, please explain _____

MEDICATIONS: Please list all medication, dosages, and times medication is to be taken. Please be accurate and complete. (If no medications taken, please write "NONE").

<i>Name of medication</i>	<i>Dosage</i>	<i>How Often</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any further medications on a separate sheet please.

Does camper take medications without problems? Yes No **Hints to help camper take medications:** _____

List all allergies: (If no allergies, please write "NONE") _____

Special respiratory treatments, physical therapy, positioning, etc: _____

****PLEASE NOTE:** All medical information will be verified during the check in process upon arrival at camp. Prescribed and over the counter medication/vitamins MUST be in the original containers—NO BAGGIES OR SUBSTITUTE CONTAINERS!!

MEDICAL RELEASE: In case of emergency, I hereby give my permission to the physician selected by the Camp Director & any medical consultants to secure proper treatment, including any & all standard medical procedures.

Print Name of Parent/Guardian _____

Signature _____ **Date** _____

Office Use Only: Verified By _____ Date _____

PERSONAL HISTORY

To be completed by parent, guardian, or adult applicant. Circle all that apply. Indicate required assistance or level of involvement.

VISION: Normal Partial loss Legally blind Total loss Glasses Contacts Other _____

HEARING: Normal Hard of hearing Partial loss Total loss Hearing Aid
Earplugs for swimming: Yes No

SPEECH: Normal Mildly affected Moderately affected Severely affected Few words Nonverbal

COMMUNICATION: Normal American Sign Language Gestures Communication Board

Other, please specify _____

Is the camper able to comprehend his/her own needs? Ex. Food, thirst, bathroom, medical assistance? Yes No

Can camper understand and respond to questions? Yes No

MOBILITY: Walks Crutches Cane Walker Wheelchair: Manual Electric Other _____

Wheelchair for long distances: Yes No Does camper independently operate wheelchair? Yes No

ADAPTIVE DEVICES: None Splints/AFO's----Hours worn: day _____ night _____

Prosthesis _____ Helmet Retainer for teeth

Other _____

TRANSFERS: No assist Partial assist/Standby Total assist Can camper support weight for transfer? Yes No

TOILETING: Independent Partial assist Total assist Colectomy Appliance Ileo Appliance

Bladder Control: Normal/No assist Occasional Incontinent Bed wetter

Schedule _____

Bowel Control: Normal/No assist Occasional Incontinent

Schedule _____

Aids used: None Needs reminder Urinal Bedpan Diapers/Frequency _____

Enema/Frequency _____ Suppository/Frequency _____ Laxative/Frequency _____

Catheter/Irrigation Schedule _____

Other _____

EATING: No assist Partial assist Total assist Cut Serve Straw Other _____

DIET: Normal Chopped food Blended/Pureed Low c\Calorie Low salt Low cholesterol Low Fat

Does camper have any difficulty swallowing? Yes No Special Utensils _____

Diabetic/ total daily calories _____ Any other special dietary needs _____

List problem foods or any food allergies _____



Association for Individual Development

Finding *ability* in disability since 1961

PRINT NAME OF CAMPER: _____
Last Name First Name Middle Name

Waiver of Liability

The undersigned, individually or as responsible party or guardian, in recognition of services rendered & benefits conferred by the Association for Individual Development hereby releases & forever discharges the employees, agents & assigns from any & all claims, demands or actions, causes of action or suit of any kind whatsoever or nature for damages sustained by the above named camper or accruing to the undersigned in consequence of any accident or occurrence resulting from the use of durable medical equipment and/or participation in any activity or program of the Association & when the above named camper is not on the premises of said agent & is not engaged in any venture or activity solely on the camper's behalf.

Signature of Responsible Party _____ Date _____

Signature of Witness _____ Date _____

Photo Release

The undersigned, in recognition of services rendered & benefits conferred by the Association for Individual Development hereby authorizes the employees, agents & assigns to release any pictures, photographs or videos taken of the above named client for publication purposes to convey information designed to inform the public of said services. The undersigned agrees to hold the Association & its agents harmless of liability should pictures or photographs, whether or not accompanied by printed material, appear in other publications published, circulated or distributed by said agents.

Signature of Responsible Party _____ Date _____

Signature of Witness _____ Date _____

Office Use Only: Verified By _____ Date _____



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Camp Forever Fee Agreement

PRINT NAME OF CAMPER: _____
Last Name First Name Middle Name

Please complete the appropriate blanks & return with completed application form. Campers who do not return the completed form will not receive a confirmation packet.

FEE SCHEDULE (Fee listed includes the \$25 non-refundable deposit)

Residents of Kane, Kendall, DeKalb Counties & Hanover Township	\$425
Non-Residents	\$525

Title XX eligible must complete and return an ACA Camper Registration Form by June 1st to determine eligibility to attend Camp Forever 2007.

FULL PAYMENT MUST BE RECEIVED BY JUNE 25, 2007

Send completed application and non-refundable deposit of \$25 to:
Association for Individual Development
ATTN: Camp Forever 2006
309 West New Indian Trail Ct.
Aurora, IL 60506

PARTY RESPONSIBLE FOR PAYMENT:

Name _____ Relationship to Camper _____

Address _____

City _____ State _____ Zip _____

Phone : _____ Signature _____

Office Use Only		
Payment Rec'd:	Balance Rec'd:	ACA form sent:
Check #:	Check #:	ACA form rec'd:
Balance Due:	Copy of Insurance Card:	ACA verification: