

2018 Texas Elks Camp Application

STOP !!!

Dear Parent or Guardian:

BEFORE you fill out the enclosed application, please take a few moments to look over the information requested.

*****EVERY blank must be completed.*****

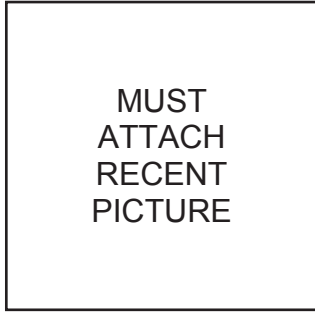
It is very important that we have ALL the information to best serve your child's needs. If we receive the application and it is not complete, unfortunately we will have to return it to you and that will delay the process.

*****Shot records must be complete and up to date!*****

The approval section **MUST BE** signed and completed by a licensed medical examiner.

*****A current photo of your child **MUST BE** attached to page one.*****

Please feel free to make additional application copies as needed or visit our website at www.texaselkscamp.org. Thank you and we look forward to seeing your camper this summer.



2018 APPLICATION

Texas Elks Camp

1963 FM 1586

Gonzales, Texas 78629

P: (830) 875-2425 F: (830) 875-5455

Email: txelks@gvec.net

“Bringing Out The Best In Special Needs Children”

Children have been served by Texas Elks Camp since 1987 without regard to income, ethnic origin, race, creed, color or religion. The main qualifying factors are at least one special need and our ability to be of service.

ELIGIBILITY

SPECIAL NEED (please check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Amputee _____ | <input type="checkbox"/> Hearing Impaired (partial) _____ | <input type="checkbox"/> Polio _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Hearing Impaired (total) _____ | <input type="checkbox"/> Rickets _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hydrocephalus _____ | <input type="checkbox"/> Scoliosis _____ |
| <input type="checkbox"/> Attention Deficit Disorder _____ | <input type="checkbox"/> Learning Disabled _____ | <input type="checkbox"/> Spina Bifida (walks) _____ |
| <input type="checkbox"/> Attention Deficit
Hyperactivity Disorder _____ | <input type="checkbox"/> Intellectually Disabled (mildly) _____ | <input type="checkbox"/> Spinal Cord Injury _____ |
| <input type="checkbox"/> Birth Defect _____ | <input type="checkbox"/> Intellectually Disabled (moderately) _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Burn Survivor _____ | <input type="checkbox"/> Multiple Sclerosis _____ | <input type="checkbox"/> Tourette's Syndrome _____ |
| <input type="checkbox"/> Cerebral Palsy (walks) _____ | <input type="checkbox"/> Muscular Dystrophy _____ | <input type="checkbox"/> Tumor Having Physical Effect _____ |
| <input type="checkbox"/> Down's Syndrome _____ | <input type="checkbox"/> Neurofibromatosis _____ | <input type="checkbox"/> Visually Impaired (partial) _____ |
| <input type="checkbox"/> Fetal Alcohol Syndrome _____ | <input type="checkbox"/> Non-Verbal _____ | <input type="checkbox"/> Visually Impaired (total) _____ |
| <input type="checkbox"/> Fragile X Syndrome _____ | <input type="checkbox"/> Perthes Disease _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other Health Impairments (please explain) _____ | | |

ELIGIBILITY CRITERIA

Potential applicants are screened and assessed on an individual basis according to diagnosis. Campers should be eligible to participate in, and enjoy, a carefully planned camping program for children with special needs. Applicants should have normal bowel and kidney function and control as well as some degree of independence in self help skills, including feeding and dressing themselves. If the above criteria is not met or answers given are found to be false, the child will be sent home.

Elks Camp is not a stationary camp program. Children who attend Elks Camp are accompanied by trained staff for daily outings to attend area attractions such as bowling, movies, indoor amusement centers and waterparks. The structure of our program may not be the most suitable for applicants that are profoundly challenged in large group settings or over stimulated by a constantly changing environment.

CAMPERS NOT ELIGIBLE

Children requiring one-on-one attention are not eligible. Also, children with the following diagnoses are not eligible:

- | | | |
|----------------------------|--|-------------------------|
| Bedfast | Osteogenesis Imperfecta | Self-injurious Behavior |
| <u>Both</u> Deaf and Blind | Physically and/or Sexually Aggressive Toward Peers | Tube Fed |
| Contagious Diseases | Prader Willie Syndrome | Uncontrolled Behavior |
| Diabetic | Profound Intellectual Disability | Wheelchair Bound |
| Hemophilia | Seizures - Grand Mal or Drop | Behaviorally Defiant |
- Children with seizure disorders may qualify if the child has been seizure free for 12 consecutive months or longer.

Children between the ages of 7 and 15 are eligible for admission / Board Policy allows a camper to attend a maximum of three years.

FOR OFFICE USE ONLY

Date Received _____ Approved _____ Date Approved _____ Confirmation Sent _____

Lodge to Receive Credit _____ Approved for Session # _____

ALL QUESTIONS MUST BE ANSWERED • **PLEASE TYPE OR PRINT CLEARLY**

If a question does not pertain to your child, please write "NA".

County _____ Date of Birth _____

Camper's Last Name	First Name	Middle Name	NAME CAMPER LIKES TO GO BY		Sex	Age
_____	_____	_____	_____	_____	_____	_____

Camper's Address (mailing)	City	State	Zip	Home Phone
_____	_____	_____	_____	_____

Custody Status (please check) Both Parents Father Mother Other _____

Guardian's Name	Address	City / State / Zip	Work Phone	Cell Phone
_____	_____	_____	_____	_____

Father's Name	Address	City / State / Zip	Work Phone	Cell Phone
_____	_____	_____	_____	_____

Mother's Name	Address	City / State / Zip	Work Phone	Cell Phone
_____	_____	_____	_____	_____

Father's Place of Employment	Mother's Place of Employment
_____	_____

Emergency Numbers in addition to those listed above: (I.e. grandparents, uncles, aunts, mobile #'s, pager #'s, etc.) **MUST BE PROVIDED**

Name	Telephone	Relation to Camper
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

Name, Address and Telephone Number of Camper's School and/or Rehabilitation Program _____

Does your child qualify for Special Education services in your school district? Yes _____ No _____

If yes, what is his/her handicapping condition? _____

Please mark preference of session by first, second, third, etc. Choices below for boys and girls ages 7 through 15.

Session 1: (June 17-22)	Session 2: (June 24-29)	Session 3: (July 1-6)	Session 4: (July 15-20)	Session 5: (July 22-27)	Session 6: (July 29-Aug 3)
_____	_____	_____	_____	_____	_____

Has Applicant attended Elks / any other camp before? Yes No When _____ Group# _____

Where _____

How did you hear about Elks Camp? School Personnel Friend Attended Elks Camp Other Camp Elk Other _____

Completion of these items below is optional:

The questions below will assist us in qualifying for U.S. government commodities, applying for some grants, and for our volunteer Board of Directors to stay informed about the children being served.

Please provide your email address if you prefer to correspond electronically for camp services (I.e., acceptance letters, items to bring, etc.).

EMAIL ADDRESS: _____

Number of members in household: _____ Is your child covered by medical insurance? _____ Medicaid? _____

Ethnic origin: _____ White _____ Black _____ Hispanic _____ Other

CAMPER'S PERSONAL HISTORY

To be completed by parent/guardian. Indicate required assistance or level of involvement. ALL QUESTIONS MUST BE ANSWERED. Check all that apply in each section. Attach additional pages as needed.

Name _____ Mental age level _____ Social age _____

EATING: No Assist Partial Assist (Explain) _____ Total Assist

Does camper have any difficulty swallowing?

No Yes (Explain) _____

List Adaptive eating equipment used _____

DIET: Normal Chopped Food Blended/Pureed Low Salt Low Calorie

Any other special diet _____

List problem foods or food allergies _____

HEARING: Normal Left Right Mild Loss Moderate Loss Severe Loss Total Loss

SPEECH: Normal Mildly Affected Moderately Affected Severely Affected

Few Words Non-verbal

COMMUNICATION: Normal Sign Language Communication Board Gestures

Other _____

VISION: Normal Partial Glasses Contacts Legally Blind Total Loss

MOBILITY: Able to Walk Wheelchair (manual) Wheelchair (electric) Crutches

Cane Walker Walk-by Assist Other _____

MOBILITY ASSIST: None Standby Total

TRANSFERS: No Assist Transfer Type: Independent Standby Stand-pivot Two Person

Other _____

ADAPT. DEVICES: None Braces Night Braces Prosthesis Helmet Glasses

Hearing Aid Dentures Shunt Other _____

TOILETING: No Assist Partial Assist (explain) _____ Total Assist

BLADDER CONTROL: Normal Partial Incontinent Needs Reminders

BOWEL CONTROL: Normal Partial Incontinent Needs Reminders

TOILETING AIDS USED: None Urinal Catheter? (Indwelling Intermittent External)

Toilet Chair Diapers Ostomy? (Colostomy Urostomy Ileostomy)

Bedpan Laxative Suppositories Enema

Other _____ List schedule for any toileting aids _____

WASHING/BATHING: No Assist Partial Assist Total Assist Aids _____

Explain: _____

DRESSING: No Assist Partial Assist Total Assist Aids _____

Explain: _____

SLEEPING: Sleepwalk? No Yes Snoring? No Yes

Need to be awakened or turned during night?

No Yes Reason _____

For Female: Has this camper menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special consideration _____

EACH QUESTION MUST BE ANSWERED

What other overnight camps will your child attend this summer?

Please list any problems (behavioral, emotional, medical, or otherwise) of which we should be aware. Include methods you have found effective for behavior management and/or therapeutic practices we need to continue at camp.

Please list any personal care issues that we need to know about. (Bathing, toileting, dressing, etc.)

Is your child afraid of anything? Does your child have nightmares? If you answered yes to either question, please describe.

Does your child know how to swim? _____ Yes _____ No

Does your child need to wear a lifejacket? _____ Yes _____ No

Does your child need to wear ear plugs? _____ Yes _____ No. If yes, plugs must be provided by parent or guardian.

Parents/Guardians responsible for transportation to and from Texas Elks Camp:

To Camp: _____

Parent/Guardian

Other

From Camp: _____

Parent/Guardian

Other

Campers leave after “Friday Night Awards Ceremony”.

Awards Ceremony starts at 5 p.m.

AGREEMENTS BELOW MUST BE SIGNED AND RETURNED.

NOTE: If you do NOT wish your child to be photographed or videotaped for promotional purposes, please check "NOT APPROVED".

PHOTO RELEASE

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to Texas Elks Camp permission to take or have taken, still and moving photographs and films including television pictures of

_____, and consents and authorizes Texas Elks Camp, their advertising agencies, news media, and any other persons interested in Texas Elks Camp, and their work, to the use and reproduction of the photographs, films, and pictures to circulate and publicize the same by all means including without limit, the generality of the foregoing newspapers, television media, brochures, pamphlets, instructional materials, books and clinical material.

With regard to the foregoing material, no inducements or promises have been made to us/me to secure our/my signature(s) to this release other than the intention of Texas Elks Camp to use or be used such photographs, films and pictures for the primary purpose of promoting and aiding their programs and their work.

Approved _____

Not Approved _____

Dated this _____ day of _____, 20 _____.

Signed: _____



TEXAS ELKS CAMP

HEALTH HISTORY FORM (Form Date: 2018)

Name: _____ Date of Birth: ____/____/____
LAST FIRST INITIAL

Primary Disability: _____

Secondary Disability, if any: _____

The Camper is under the care of Dr. _____
for the following condition(s): _____

HEALTH HISTORY:

(Check. Give approximate dates)

- _____ Frequent Ear Infections
- _____ Heart Defect / Disease
- _____ Seizure Disorders
- _____ Epilepsy
- _____ Diabetes
- _____ Bleeding / Clotting Disorders
- _____ Hypertension
- _____ Mononucleosis
- _____ Asthma

ALLERGIES (Check if applicable)

- _____ Hay Fever
- _____ Poison Ivy
- _____ Insect Stings
- _____ Penicillin
- _____ Other Drugs
- _____ Foods
- _____ Other

Explain _____

DISEASES

- _____ Chicken Pox
- _____ Measles
- _____ German Measles
- _____ Mumps

Will your child continue his/her meds during camp?

List of current medications: _____

Please elaborate on any of the above if necessary: _____

Has this camper ever required any psychiatric counseling / hospitalization? _____ Yes _____ No Explain _____

Operations or injuries that currently impact child : _____

Has your child ever attempted suicide: _____ Yes _____ No If yes, When? (date) _____

Explain Circumstances _____

WE RECOMMEND THAT YOUR CHILD'S MEDICATION NOT BE CHANGED BEFORE CAMP.

AGREEMENT AND AUTHORIZATION FOR TREATMENT

Although the risk is minimal, I understand Texas Elks Camp is not liable for any injury sustained by _____ while attending Camp. The Camp is not responsible for personal items lost, misplaced, etc. Any drawings, ceramics, and/or crafts, done by my child and left with the camp may be used to demonstrate to other children and supporters what can be done at Camp.

I hereby authorize:

- (a) Physicians, nurses, hospitals and their authorized personnel employed, contracted, or paid on a fee basis by the Camp to perform all treatments and procedures as deemed necessary; and,
- (b) Release of medical/hospital records to the Camp from existing medical/hospital records; and,
- (c) Release of medical/hospital records possessed by the Camp to physicians, nurses, hospitals and their authorized personnel for the performance of treatments and procedures as deemed necessary upon my child.

My child agrees to comply with all rules concerning conduct and organization. My child and I understand failure to comply may result in dismissal from Texas Elks Camp.

Signature _____ Date _____
(Parent or Legal Guardian)

Signature _____ Date _____
(Child, if possible)

— PARENT/GUARDIAN STOP HERE —

(The Medical Evaluation on Page 9 MUST BE COMPLETED by a licensed doctor of medicine.)

The medical Evaluation cannot be conducted by an RN or an LVN.

The following **MUST BE COMPLETED** with **CURRENT** information. Ask a school nurse for help if needed.

Child's Name: _____

Name of dentist/orthodontist: _____ Phone:(_____)_____

Medical/hospital insurance _____ Yes _____ No If yes, indicate Carrier _____

Policy or Group # _____

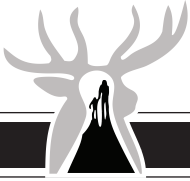
Is camper on Medicaid? _____ Medicaid # _____

IMMUNIZATION HISTORY

A current immunization form from the school or doctor should be attached. **This application will be considered "unable to process" if a copy of the current immunization record is not provided.**

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted by me and/or the licensed medical examiner.

Signature of Parent/Guardian: _____ Date: _____



TEXAS ELKS CAMP

HEALTH EVALUATION/EXAMINATION FORM (Form Date: 2018)

The Medical Evaluation should be completed by a licensed medical examiner and can be based on an examination done no more that 12 months prior to Camp.

Camper Name: _____ Current Height: _____ Current Weight: _____

Date of Medical Evaluation: _____ Date of last physical examination: _____
(No more than 12 months prior to camp)

Current list of all diagnoses: _____

Any treatment to be continued at camp: _____

Any reported loss of consciousness, convulsion, or concussions: (explain) _____

Any medication to be administered at camp (provide medical order for administration): _____

Can Camper take Tylenol? _____

Any medically prescribed meal plan or dietary restrictions: _____

Any Allergies (food, drug, plants, insects, etc.): _____

Treatment for allergic response: _____

Activities encouraged: _____

Activities limited: _____

Additional Health Information: _____

Atlantoaxial Dislocation Condition: This camper ____ **has** ____ **does not have** Down Syndrome. A.D.C. has been checked for by x-ray and has been ruled out, enabling this child to safely participate in physical activities.

APPROVAL

This application will be considered "unable to process" if this section is not completed with the requested information by the licensed medical examiner.

I approve camping activities with supervised participation in physical activities to include but not limited to swimming, bowling, dancing and non-contact sports. Any necessary limitations in activities have been listed in the provided area above on this examination form.

EXAMINER'S SIGNATURE _____ DATE _____

ADDRESS _____

CITY & STATE _____ PHONE NUMBER (_____) _____

PRINT EXAMINER'S NAME _____