Colorado Lions Camp

"The Camp Above the Clouds"

Mailing address: PO Box 9043, Woodland Park, CO 80866
Physical Address: 28541 HWY 67N, Woodland Park, CO 80863
Phone: 719-687-2087 Fax: 719-687-7435

Email: coloradolionscamp@msn.com
Website: www.coloradolionscamp.org

Dear Camper/Caregiver/Family:

Welcome to the Colorado Lions Camp! Thank you for your interest in attending our Weekend Respite Camps. We have many fun & exciting activities planned, and look forward to seeing you there. Please note, we will have a total of 10 spots open for each scheduled weekend. Openings will be filled on a first come, first serve basis, so please make sure to complete your application quickly. There are a limited number of camperships available for those who are eligible for financial assistance. Get ready for an awesome time!

RESPITE CAMP DATES:
November 10-12, 2017
February 9-11, 2018
April 6-8, 2018

This is what we need from you in order to register for respite weekend.

□ **– Completed 2017-2018 Respite Camper Application (pages 1-6)**
*****All paperwork must be filled out completely and signed.

□ **- Camp Registration Fee - $50.00** - Check, Money Order or Credit Card or unless billing Medicaid or agency, then no registration fee is required. ***Please make checks/money orders payable to: Colorado Lions Camp***

RESPITE COST: $200.00 (includes the $50.00 registration fee)

MEDICAL FORMS: Physicals no later than **12 MONTHS** from your selected camp date will be accepted. All new campers are required to have a current physical on file at camp. The physical must be signed by a physician and can be on CLC's camp form, another camp form or report from the physician's office. Physicals **MUST ARRIVE NO LATER THAN TWO WEEKS PRIOR to the camp session you are accepted to.**

Please call the Lions Camp @ (719) 687-2087 for any additional information.

Yours in Camping,

The Colorado Lions Camp

Colorado Lions Camp
RESPITE CAMP PROGRAM

The Colorado Lions Camp mission is to provide exceptional camping programs to individuals with special needs which promote independence, challenge their abilities and provide opportunity to discover his/her own potential in a safe, positive environment.

Eligibility Requirements:

1. Our program is specially designed to meet the needs of campers age 8 to senior adult, and who are: deaf or hard of hearing, blind or visually impaired, developmentally challenged, physical impairments and other mental conditions. Campers who are wheelchair users must be able to perform the basic independent living skills and be able to use the toilet facilities without assistance. Campers must be able to maneuver up/down an incline, as the camp is built on a mountainside. If you have any questions regarding eligibility, please contact the camp at (719) 687-2087.

2. Applicant will be required to possess basic independent living skills such as, self-feeding, showering, dressing and toileting. **Applicant must be continent, have normal bowel and kidney function and control.** Applicant must display self-sufficient skills as to **NOT require one-on-one supervision** and can be managed with a 1:4 staff to camper ratio. Due to the age range of our campers, no camper will be accepted that cannot be in contact with those under 18.

Applicants that are NOT accepted:

1. Incomplete applications.
2. Persons that have a contagious or infectious disease.
3. Persons who are incontinent and unable to take care of their personal hygiene needs.
4. Persons who are medically fragile, whose needs exceed our ability to care for them adequately.
5. Persons with challenges that would limit their ability to benefit from camp group activities.
   (**This includes physical, behavioral, and/or emotional issues that would require one-on-one supervision).**

***During Respite Weekends, a licensed RN, LPN or QMAP trained staff member will be available to administer medications. Staff members are first aid and CPR certified. All emergencies will go straight to the local hospital.**

Letter of Confirmation

If eligible, a letter of confirmation and packing list will be mailed to the applicant or parent/caregiver upon acceptance.

Cancellation Policy

All advanced fees paid will be refunded in full if notice is received in the Colorado Lions Camp office within fifteen (15) days prior to the applicants' session. If less than fifteen (15) days notice is received, all but the deposit will be refunded. If the applicant has not paid the deposit, the applicant will be billed. Promptly notify the camp in the event of a cancellation.

Colorado Lions Camp
IMPORTANT CAMP INFORMATION

1. **Check-In Time:** Registration starts at **6:00 p.m.** and will continue until **7:00 p.m**. on the Friday of each designated respite weekend. Lions/agencies/parents/caregivers will be required to stay through the entire check-in process. You may choose to sign an inventory waiver to expedite the check-in process, but you will still need to meet with our Camp Nurse and CLC Director. **We are unable to accommodate early check-ins.**

2. **Check-Out Time:** **Camper check-out is no later than 11:00am on Sunday afternoon**. There will be a $25/hour charge for all late pickups, so please plan accordingly.

3. **Clothing List and Special Equipment:** A detailed clothing list will be provided upon notification of acceptance to the camp. Please bring warm clothing. Laundry facilities are not provided. All clothing and special equipment should be clearly marked with the camper's full name **BEFORE** check-in on Friday. **The camp is not responsible for lost, misplaced, or damaged items. Soiled clothing may be discarded and not returned.**

4. **Supervision:** Activities are well supervised and staff members are required to complete the CLC training program. Supervision is provided 24 hours a day; however, 1:1 supervision is **NOT** available. In addition, we cannot accept individuals who are not permitted to be around persons under 18 years of age.

5. **Health Care/Med Check-In Procedure:** Medical personnel are on-duty 24 hours a day for the duration of the respite weekend. The Camp Nurse is responsible for administering all medications as ordered by the physician or CLC Standing Orders. Doctors are on-call for CLC in the event they are needed. **A three-day supply of medicine must be sent with your camper for respite weekends.** All medication (pills) **MUST** be pre-poured into a med minder box by the camper's pharmacist/parent/caregiver/agency. You will need to include the original prescription bottles with one pill inside and/or bubble packs with remaining pills for verification. Any medication changes must be verified by a physician in writing or the camp's medical staff will refuse to administer it. Any medication not in the original container will not be accepted. A signed liability release statement must be signed by the person who pre-poured the medication(s) and provided to the medical staff at the time of check-in. Parents/caregivers will be contacted if medication problems arise. **Nonprescription, dietary supplements and homeopathic remedies will NOT be given at camp unless prescribed by a physician.**

6. **Scheduled Activities:** Arts and crafts, miniature golf, hobbies, nature studies, exploring, games, hiking, archery, storytelling, singing, dancing, pool, air hockey, board games, team building, and open camp fire are some of the activities that may take place during the session. Persons trained in that area of interest will oversee all activities.

7. **Facilities:** Dormitories, medical exam room, out-post camp, two story main lodge, on 46+ acres.

8. **Insurance:** Campers are covered by the camp's accident insurance during their stay. Pre-existing conditions are covered by the individual's group medical insurance during the period they are at camp. Insurance of the family/caregiver/camper has first coverage. It is imperative that insurance and medical information be provided on the attached forms.

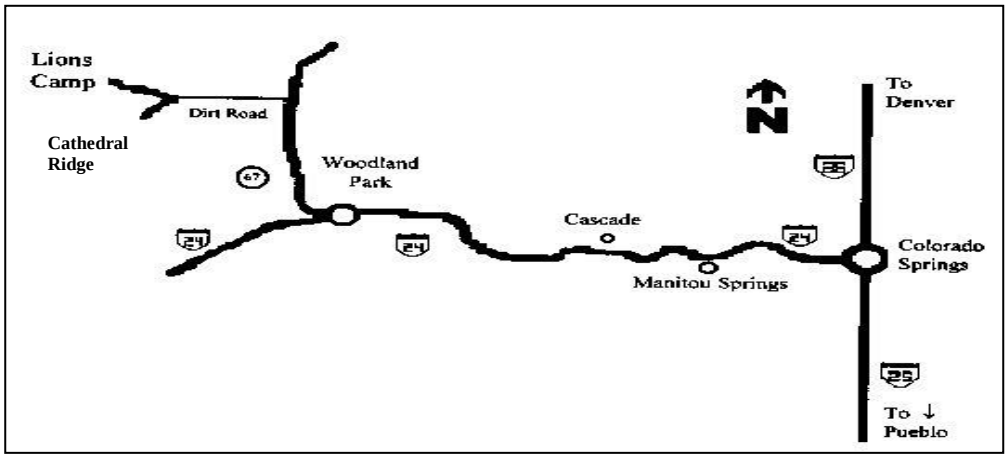
9. **Licensing:** The Colorado Lions Camp is licensed annually, according to the standards of the Colorado Department of Human Services and the Colorado Department of Health.

10. **Transportation:** Parents/Guardians/Caregivers are responsible for arranging transportation to and from camp. The camp does not provide transportation, nor cover the cost of transportation.

Where are we Located?

Camp Physical Address:
(do not send mail to this address)

28541 Hwy 67N
Woodland Park, CO
80863



- **From I-25 in Colorado Springs take US 24 West (Exit 141) towards Pikes Peak and Manitou Springs.**
- **In Woodland Park turn North US 67 North.**
- **Proceed for four miles and you will see a large yellow sign on the left pointing towards to the camp. (On the right side you will see a sign Red Rocks Campground)**
- **Turn left at the sign onto the dirt road and keep to the right at the fork in the road. It is approximately one mile from HWY 67.**

How do I prepare my camper's medication for check-in?

All medication, vitamins and supplements must be pre-poured/prepackaged in a med minder box by a pharmacist, parent/caregiver, or agency. See pictures listed below.

	• Packaged at home in a med-minder box for each day of the week. If the camper has meds throughout the day at different times, please provide weekly boxes for breakfast, lunch, dinner or other time meds.

Please bring the pre-poured med minder box, the original prescription bottle(s) and/or bubble pack(s) showing the current prescription information, **AND** the signed liability release statement signed by the caregiver/parent/agency who poured the medication. Each bottle must contain one pill be left inside the bottle for verification purposes. This includes vitamin and homeopathic supplements prescribed by a physician.

*You will receive additional information in your camper confirmation packet. Please ensure this process is followed to allow for the check-in process to go as smoothly as possible.

COLORADO LIONS CAMP
PO Box 9043
Woodland Park, CO 80866
(719) 687-2087
Fax# (719) 687-7435
Email: coloradolionscamp@msn.com
Website: www.coloradolionscamp.org

For Office Use Only:
Application Rec'd _____ Approved by_____
Deposit Rec'd _____ Week _____
Campership _____

Name Tag _____ Nurse_____ Entered _____
Conf. Pkt. Sent _____

Respite Camp Application

All pages 1 -7 of the application MUST be completed and returned to our office for registration. *Applications are processed on a first come, first served basis.* ***DO NOT*** *wait for medical forms to be completed before sending in your application. Many of our sessions fill up quickly and you may not be placed in your first choice.*

Camper's Name_____ Nickname_____

Camper's Mailing Address_____

City_____ State_____ Zip Code _____

Age_____ Date of Birth_____Sex: M / F Returning camper? Yes or No T-Shirt Size: _____

Parent/Caregiver/Group Home Name and Address_____

Phone Number: Home: (____)_____ Work: (____)_____

Parent's Employer Name & Address_____

Camper lives with: ☐ Independently ☐ parents ☐ group home ☐ host home ☐ foster family

How do you wish to receive camp confirmation? (please circle) Mail (Camper address or agency) Email or Fax
Email (Parent/Caregiver/Agency)_____ Fax: _____

Agency Name and Mailing Address_____

#1 Emergency Contact Information
(Must be someone OTHER than above listed parent/guardian)
Name_____ Relationship_____
Phone_____

#2 Medical Emergency Contact Information
(Who should be contacted if the camper needs to go to the ER, etc.?)
Name_____ Relationship_____
Phone_____

Choice of Respite Camp date: First_____ Second_____

PAYMENT INFORMATION: (This portion must be filled out for ALL campers.)

*** Camp costs $200.00. The $50.00 registration fee is part of the total camp fee.**
*** Full payment is due by the start of the session, unless a CCB/Agency has agreed to pay the full camp fee or the camp will be billing Medicaid.**
*** CLC accepts credit card payments for full camp fees. Call the camp office for more information.**
*** No refunds will be made if the camper leaves camp because of behavior problems, illness, or other reasons by the Executive Director.**

The Camper's fee will be paid by (please fill in all that apply):
$_____Parents $_____Self $_____Medicaid SLS or CES Waiver $_____Agency $_____CCB

If CCB or Agency will be paying, please fill out the following information completely:
Name of Agency/CCB:_____ Contact Person:_____
Phone Number: _____

The Colorado Lions Camp is licensed through the Department of Human Services, and as the licensing agency, they require the following information. The Civil Rights Act of 1964 prohibits the discrimination based on race, color, religion, sex, nor national origin. This information will not be used to determine the eligibility of your camper.

Ethnic Heritage: (circle one) Asian Hispanic Black Native American White Other_____

Please provide the name(s) of anyone not authorized to pick up camper: _____

PARENT/CAREGIVER CHECKLIST

Camper Name_____

PLEASE READ AND INITIAL ALL THE FOLLOWING LINES AND RETURN WITH APPLICATION:

The camper application and camper questionnaire forms are **completely** filled out and signed by the legal guardian. Please note that these forms should be forwarded to the camp as soon as possible to reserve your preferred camp date. INITIAL____

The medical form is completely filled out by authorized medical personnel only and signed by a doctor. *All campers must have a medical report on file with the camp no older than 12 months of the date of their camp session.* Medical forms must be returned **TWO WEEKS** prior to camp. **Failure to return the Medical Report may result in the camper being dropped from the session and no refund will be given.** INITIAL____

I understand that all medications MUST be pre-poured in a med-minder box by a pharmacist, parent/caregiver, or agency. I must bring the original bottles with one pill in the original container and/or complete bubblepack with remaining pills (this includes vitamin supplements.) Any changes in how the medication is given, or in a dose that differs from those on the bottle, must be verified by a physician in writing or the our medical staff **WILL REFUSE** to administer medication. Any medication not in the original container will not be accepted. A signed liability release statement must be signed by the person who pre-poured the medication to give to the nurse at the time of check-in. Nonprescription, dietary supplements and homeopathic remedies will NOT be given at camp unless prescribed by a physician. INITIAL____

I understand that the Colorado Lions Camp does **NOT** provide **1:1 supervision** and if the camper has inappropriate behaviors or requires 1:1 attention, the camp may require me to pick up the camper before the end of the scheduled session**. No refunds will be made due to an early departure**. INITIAL____

All advanced fees paid will be refunded in full if notice is received in the CLC office fifteen (15) days prior to the applicants' session. If less than fifteen (15) days notice is received, all but the deposit will be refunded. If the applicant has not paid the deposit, the applicant will be billed. INITIAL____

CHECK-IN: is **Friday** between the hours of **6:00 p.m. and 7:00 p.m**. A parent/caregiver or other authorized person will be required to assist the camper during the entire check-in process. INITIAL____

CHECK-OUT: is Sunday by 11:00 p.m. for all campers. There will be a $25/hour fee charged for all late pickups. Please plan accordingly. INITIAL____

I understand that upon receipt of medical report, a review of the report by the CLC Camp Nurse and/or Director may result in the cancellation of the camper's session due to unforeseen circumstances. In the event this occurs, you will be contact directly by the appropriate CLC Staff.

Signature_____ **Date**_____

Camper Name_____

CAMPER QUESTIONNAIRE

The care of the camper depends information provided on this form. Please answer all questions to the best of your ability and please be specific on any details that will be helpful in caring for the needs of the camper. This questionnaire must be completed before acceptance letter can be sent.

Primary Diagnosis: _____ Secondary Diagnosis: _____
Approximate functional age level: _____

ALLERGIES: List ALL types, food, drug, environmental, etc.:

Allergy	Symptoms	Treatment

Does camper have an allergy that requires an Epi-pen? _____

Behavior/Social Interaction *(please check all that apply or have occurred within the past year)*

	NO HISTORY		Destructive		Self-Abusive		Inappropriate Sexual Behaviors
	Gets upset easily		Physically Aggressive		Invades Space		Sexually Aggressive
	Pulls hair		Threatens		Wanders/Runs Away		Sexually Passive
	Hits/Scratches others		Curses/Verbally Abusive		Screams		Other:
	Bites		Lies or Steals		Bangs Head		

How often do these behaviors occur? (Please circle)

Seldom (1X or less per month) Often (1X or less per week) *Frequently* (more than 1X per week) *Daily*

Does camper have a safety plan or behavior management plan in place? (If yes, please submit copy with application) _____

Please describe in detail these or any other challenging behaviors we should know about: _____

_____

Do you have specific ways or use "key phrases" of handling behavior? _____

_____

What usually triggers challenging behavior? _____

_____

During the past year, has the camper seen or is currently seeing a professional to address mental/emotional health concerns? Yes ( ) No ( ) If yes, please give a brief plan of care camper is following: _____

_____

Has the camper had a significant life event (death of a loved one, family change, group home change, trauma, etc) that has occurred in the last year? Yes ( ) No ( ) If yes, please specify and give additional detail as needed: _____

_____

Has camper ever attended camp before? ( ) YES ( ) NO If yes, name of camp:_____

What hobbies/activities/interests does camper enjoy doing? _____

Does camper have any fears? _____

Toileting/Showering & Dressing *(please check all that apply)*	Independently	With Verbal Cues	Some Assistance	Total Assistance
Uses Toilet* (see below)				
***We understand that toileting accidents occur.** Please circle frequency: Never Rarely Occasionally Frequently ***Camper must be continent. Depends are okay, but camper must be able to change and cleanup without assistance. Staff is unable to assist with wiping.**				
Menstrual Care				
Shampooing/Soaping				
Showering				
Hair Care				
Brushing Teeth				
Dressing				

Camper Name_____

QUESTIONNAIRE (CONTINUED)

Is camper capable to care for and keep track of his/her own belongings? _____ Yes _____ No

ALL CLOTHING AND PERSONAL ITEMS NEED TO BE LABLED WITH THE CAMPERS FIRST & LAST NAME

The Camp is not responsible for lost, misplaced, or damaged items.

The camp is built on the side of a mountain, and the camper dorms are uphill from the Main Lodge. Is the camper physically capable to walk or maneuver up a steep hill?
Yes ( ) No ( ) Comments:_____

Communication: *(circle all that apply)* VERBAL NON-VERBAL SIGN LANGUAGE GESTURES
READS LIPS MAKES NEEDS KNOWN HEARING LIMITATIONS
COMMUNICATION DEVICE? _____

Specific Eating Requirements: (circle all that apply)
No assistance Some assistance Food needs to be cut Diabetic diet Gluten-free diet Lactose Intolerant
Food Allergies Only (**what degree/reaction**): _____
Does the camper have any special dietary requirements? _____

List all specialized equipment that will be brought to camp _____

EMERGENCY MEDICAL INFORMATION

This is in **addition** to the medical form from your doctor.

INSURANCE INFORMATION:

(Application cannot be accepted until all information is completed in this area)

PLEASE ATTACH A COPY OF INSURANCE/MEDICAID/MEDICARE CARD

Health Insurance Company (if no insurance, please write none) _____
Co. Address _____ Telephone _____
Policy # _____ Certificate # _____
Name of Insured _____ Company Name _____
Employer Contact: Name: _____ Telephone _____

Camper Name_____

MEDICATIONS: (TO BE FILLED OUT BY PARENT/CAREGIVER/AGENCY)

All medication must be pre-poured in a med-minder box and the original bottles with one pill in the original container and/or bubblepack with remaining pills (this includes vitamin supplements) must be brought to camp for pill verification.

Colorado State Law and Regulations require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) for the nurse or designated trained personnel to administer medication. Please provide complete information on all medications, including prescription and non-prescription medications, dietary supplements, and homeopathic remedies. **Nonprescription, dietary supplements and homeopathic remedies will NOT be given at camp unless prescribed by a physician.**

Any changes in how the medication is given or in a dose that differ from those on the bottle must be verified by a physician in writing or the healthcare staff **WILL REFUSE** to administer it.

PLEASE CHECK ONE OF THE FOLLOWING:

☐ - Camper takes no medication

☐ - Camper takes daily medication as follows: **standard camp medication times are listed in the chart below. Please complete the chart with accurate and current medication information**

MEDICATION SHEET
PLEASE PRINT CLEARLY
Any attachments must clearly state the medication, dosage, and reason for use and the time meds must be given.

Medication	Dosage	Reason for Use	8:00am Breakfast	12:00pm Lunch	3:00pm	5:30pm Dinner	8:30pm Bedtime	Other

Does the camper experience any side effects from the above medications? ( ) YES ( ) NO

If yes, please explain._____

The health history is correct, to the best of my knowledge, and the applicant has permission to engage in all activities, except as noted. Exceptions: _____

PERSONS CHECKING-IN CAMPERS must be able to answer questions regarding camper's medication, special diets, and medical equipment.

If there is a change in the participant's health or medications, or if they have had surgery within 3 weeks prior to arriving at camp, PLEASE contact the Executive Director at (719) 687-2087 to determine if we are able to care for this participant.

By signing this application, I agree that the information included throughout is complete and true to the best of my knowledge. If there are any changes to medication or condition of participant I agree to notify Colorado Lions Camp at least 2 weeks prior to camp session the participant will be attending.

Form completed by: _____ Date: _____/_____/_____

Camper Name_____

PARENT/LEGAL GUARDIAN AGREEMENT

Please read carefully, sign below and return with camp application

I hereby give consent for the camper named above, to participate in all Colorado Lions Camp sponsored programs and supervised activities. I certify that the information on the application is true, accurate, and complete. CLC emphasizes safety first; however, participation in CLC programs has inherent risks that may result in injury.

I do hereby agree to indemnify and hold the Colorado Lions Camp and its agents, servants and/or employees harmless from any and all damages, claims, expenses or costs of whatever nature, causes of action, suits and liability of every kind including attorney fees, for injury to or death of my camper, or for damage or loss to any property, arising out of or in connection with my camper's use or occupancy of the premises or participation in the Colorado Lions Camp programs, except where such injuries, death, damages or loss are caused in whole or in part by negligence of the Colorado Lions Camp, or joint negligence of the Colorado Lions Camp and any other person or entity employed by the Colorado Lions Camp.

I understand that the program will include not only normal activities conducted on the campgrounds, but also opportunities for off-site activities that will require transportation to and from camp as well as trips that will involve walking/hiking away from camp.

PUBLICITY RELEASE
Colorado Lions Camp uses photographs, images or recordings of campers for publication in brochures, email, website and various other media to promote services or to recruit volunteers and staff. The camper named above **MAY be included** in these promotional materials unless you contact the camp directly. ACCEPT____ or DECLINE____

AUTHORIZATION FOR CARE
I hereby grant permission to all physicians, nurses, and hospitals and their authorized employees to render routine medical care deemed necessary for my camper. We desire notification at a telephone number, which we agree to supply, or other appropriate means, of any such emergency or other circumstances likely to have an adverse effect upon our camper's health, including notification of any emergency treatment. ACCEPT____ or DECLINE____

MEDICAL REPONSIBILITY
I understand that regardless of my assigned insurance benefits, I am responsible for total charges in consideration for services rendered. CLC cannot assume responsibility for any medical expenses that may occur if medical care must be sought.
ACCEPT____

RELEASE OF INFORMATION
I authorize release of any medical information requested by representatives of local, state or federal agencies, insurance companies or other organizations as may be required for payment of claims. ACCEPT____

ASSIGNMENT OF BENEFITS
If a Medicare patient, I certify that the information given by me in applying for payment under TITLE XVII of the Social Security Act is correct. I request the payment of authorized benefits be made in my behalf. ACCEPT____

NOTICE OF PRIVACY
In accordance with the Health Insurance Portability and Accountability Act (HIPPA) of 1996, clients of Colorado Lions Camp are entitled to the greatest degree of privacy possible. Colorado Lions Camp will strive to ensure that client information is used only for the authorized purpose as agreed to by the client.

_____ _____

REQUIRED – Signature of applicant, if legally represents self; parent, legal guardian or authorized person **Date**

Colorado Lions Camp Phone (719) 687-2087
PO Box 9043 Fax (719) 687-7435
Woodland Park, CO 80866
coloradolionscamp@msn.com

FOR OFFICE USE ONLY:
Date Rec'd_____
Session _____

Camp Physical Examination Form

This form must be completed and signed by a Licensed Physician NOT by a parent or caregiver.

We request this form or a copy of a physical dated no later than **12 months** from your camp date be received in our office at least **TWO WEEKS** prior to scheduled camp session.

Name:_____Date of Birth _____/_____/_____ Male_____ Female_____

Diagnosis:_____

Is any condition present, which may result in an emergency? Please describe: _____

Allergies (Drug/Food/Environmental)? Epipen required? _____

EXAMINATION COMPLETED BY DOCTOR

Height: Weight:	Mouth/Throat/Nose:
Pulse: BP: Temp:	Neck/Thyroid & Lymph Sys:
Hearing Loss: NONE PARTIAL COMPLETE Hearing Aids Worn? Cochlear Implant?	Nervous System/Reflexes/Gait/Sensations:
Vision Loss: NONE PARTIAL COMPLETE Glasses Worn? Contacts Worn?	Bringing to camp: CPAP or Oxygen (CIRCLE) DAY NIGHT (CIRCLE)
Cardiac:	GI Distress - upper - lower (please specify)
Lungs:	Headaches:
Abdomen:	Bedwetting:
Musculoskeletal:	Incontinence – Urinary - Fecal (please specify)
Back/Spine:	Respiratory/Asthma/Emphysema (please specify)
Skin:	Sleep Apnea/COPD:
Diabetic: Insulin: YES NO Frequency of glucose monitoring:	Seizures: Type: Frequency: Last:
Mobility	Uses: WALKER CANE WHEELCHAIR

PREVIOUS ILLNESS (give age when these occurred): Chicken Pox _____ Measles _____
Mumps _____ MRSA _____ Shingles/Herpes _____ Strep Throat _____ Hepatitis _____
Frequent UTI _____ Frequent URI _____ Chronic Cough _____ High BP _____ Other _____

IMMUNIZATION HISTORY Please give dates (month/year) of immunizations and most recent booster dates:
(DPT) _____ MMR _____ Polio _____ Smallpox _____ Influenza _____
TB Test _____ Hepatitis b series _____ Tetanus _____ Type _____**(REQUIRED)**

***Campers ages 8-21 must attach copy of current immunization record. If records are unavailable, please send statement to that effect. Statement "up-to-date" not acceptable.**

QUESTIONNAIRE

Is camper free from communicable diseases? YES/NO If no, please describe: _____

How would you access the applicant's current health? GOOD FAIR POOR

Has the applicant been hospitalized or treated in the emergency room in the last year? YES NO
If yes, please explain._____

Is the applicant a carrier of Hepatitis B or C has he/she been exposed to Hepatitis B or C? YES NO

Are there medical reasons to limit or restrict this individual from participating in the following camp activities: swimming, horseback riding, supervised ropes course, hiking, and archery? _____Any limitations?_____

Is this applicant on medication? YES NO (Please see back of form)

Camper's Name: _____

Colorado State Law and Regulations require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) for the nurse or designated trained personnel to administer medication. Please provide complete information on all medications, including prescription and nonprescription medications, dietary supplements, and homeopathic remedies.

Nonprescription, dietary supplements and homeopathic remedies will NOT be given at camp unless prescribed by a physician.

All changes in medication prescriptions or dosages must be verified by a physician in writing or the CLC medical staff **WILL REFUSE** to administer it.

PLEASE CHECK ONE OF THE FOLLOWING:

☐ - Camper takes no medication

☐ - Camper takes daily medication as follows: **standard camp medication times are listed in the chart below. Please complete the chart with accurate and current medication information.** If camper cannot adhere to these times, please indicate alternate time and why medication must be given at that time. Please indicate number of tablets, capsules, amount of liquids, or puffs of inhalers, etc. in the box below the time medication is given.

MEDICATION SHEET
PLEASE PRINT CLEARLY

Any attachments must clearly state the medication, dosage, and reason for use and the time meds must be given.

Medication	Dosage & # of pills, puffs, liquid	Reason for Use	8:00am Breakfast	12:00pm Lunch	3:00pm	6:00pm Dinner	8:30pm Bedtime	Other

Does the camper experience any side effects from the above medications? ( ) YES ( ) NO

If yes, please explain._____

May take over the counter medications, if necessary? YES / NO Initial ___

May we contact you if we need more information? YES / NO

Physician's signature: **(MANDATORY)**_____ Date _____

Physician's Name (Please Print) _____ Phone: _____

Address, City, State, Zip: _____

Name of Person Filling out Form and Title:_____