



## CAMP HAPPINESS PROGRAM APPLICATION 2011

Consumer Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Parent/Family Member Name \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ Home Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Work phone # \_\_\_\_\_ ext \_\_\_\_\_

SS # \_\_\_\_\_ Gender Male \_\_\_\_\_ Female \_\_\_\_\_

Medicaid # \_\_\_\_\_ Allergies \_\_\_\_\_

\_\_\_\_\_

Other Health Insurance Please list Carrier and group #

\_\_\_\_\_

**A photo copy of front and back of health insurance card must be attached to this form**

Adapted Devices (ex. Wears eyeglasses, utilizes walker, hearing aid etc.)

\_\_\_\_\_

\_\_\_\_\_

Emergency Contact Person (someone outside of the residence where they live)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Medicaid Service Coordinator/Case Manager

Name \_\_\_\_\_ Agency \_\_\_\_\_

Phone # \_\_\_\_\_ Cell phone # \_\_\_\_\_

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Medical Status: list chronic health concerns (allergies, cardiac difficulties, asthma, any physical restrictions, seizures, avoid excessive sun exposure Please include approximate date of last seizure.

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**Prescription Medications**

Medication	Form Pill/Capsule Suspension (liquid) Topical Cream	Times Taken	Taken With food/drink	Dosage

**Level of Assistance: Check Appropriate Box**

Skill Area	Independent	Reminders required	Moderate Assistance	Maximum assistance
Dressing				
Bathing/showering				
Ordering				
Hygiene				
Feeding				

Physical Restrictions for activities (Please be specific) \_\_\_\_\_

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Can he/she tolerate water Swimming (any allergies to chlorine) \_\_\_\_\_

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Specific Fear/Dislikes (heights, amusement park rides (list specifics) large crowds, dogs

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Dietary restrictions: (Please be specific)

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Favorite Foods \_\_\_\_\_

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**Parent/Guardian Authorizations:**

This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to Opportunities Unlimited and Camp Happiness staff (Lockport YMCA) to give first aid, administer prescription medications, (nurse will be present) and seek emergency medical treatment including ordering x rays or routine test. (if necessary) I agree to the release of any records necessary for insurance purposes.

I give Opportunities Unlimited and Lockport YMCA permission to arrange necessary related transportation for my child. In the event I can't be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of camper/minor \_\_\_\_\_ Date \_\_\_\_\_

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