

**Camp Civitan 2008
 Parent Information Packet**

Enclosed please find the 2008 Civitan Foundation's summer camp schedule. As you can see we have extended the schedule through the end of August, and a week in September. Camp will be 7 nights: Saturday to Saturday. The respite rate of 102 hours will remain the same and private pay will be \$595.00 per week, all weeks will require \$50 activity fee, which are associated with the field trips, arts and crafts, off camp activities and meals. Transportation is available on a first-come basis, and wheelchairs are limited each week. All applications must be completed in full and accompanied by a deposit. At that time we will process information and schedule intake interviews for applicants. We are now also accepting applications for direct care staff (paid positions), and youth volunteer counselors. We look forward to seeing you and your campers this summer.

Camp Civitan 2008 Main Summer Programs:

The Civitan Foundation is a non-profit organization dedicated to individuals with Developmental Disabilities since 1968. Camp Civitan is our longest running program offering overnight camping experiences in Williams Arizona. **The Civitan Foundation is a qualified vendor with DDD/DES and is able to accept respite for camping experiences.** We pride ourselves on the fact that each year we have many returning happy campers. Camp is designed to foster many types of peer socialization, educational programs, life skills, physical activities, gross and fine motor skills, teamwork, healthy living, food and nutrition, and lots of fun. Each session has a theme or includes some type of field trip, guest speakers from the local communities, arts, crafts, fishing, hiking and swimming just to name a few.

*Activities are all subject to weather and other uncontrollable situations and availability.

Weeks do sell-out, please confirm your desired space ASAP.

Camp Civitan 2008 Field Trips *Please remember these activities are subject to change.*

Dates	Depart Arrive	SUMMER CAMP WEEKS Activity Descriptions	Private Pay Amt	Respite Hrs	Activity Fee	Charter Bus
May 31- June 7	Sat. 9am- Sat. 4pm	Grand Canyon Expedition/Imax	\$595	102	\$50	\$30 depart \$30 return
June 7-14	Sat. 9am- Sat. 4pm	Grand Canyon Railways	\$595	102	\$50	\$30 depart \$30 return
June 14-21	Sat. 9am- Sat. 4pm	Kids Week Deer Farm/Flintstones Park (Ages 5-14) (Ages 15-22) separated	\$595	102	\$50	\$30 depart \$30 return
June 21- June 28	Sat. 9am- Sat. 4pm	Star Gazing/ Lowell Observatory	\$595	102	\$50	\$30 depart \$30 return
June 28- July 5	Sat. 9am- Sat. 4pm	Renaissance in the Pines	\$595	102	\$50	\$30 depart \$30 return
July 5-12	Sat. 9am- Sat. 4pm	Patriotic week	\$595	102	\$50	\$30 depart \$30 return
July 12-19	Sat. 9am- Sat. 4pm	Cowboy Western Week	\$595	102	\$50	\$30 depart \$30 return
July 19-26	Sat. 9am- Sat. 4pm	Sixties Week/Sock Hop/Grand Canyon Caverns	\$595	102	\$50	\$30 depart \$30 return
July 26- Aug.2	Sat. 9am- Sat. 4pm	Grand Canyon Expedition/Imax	\$595	102	\$50	\$30 depart \$30 return
Aug 9-16	Sat. 9am- Sat. 4pm	Boy's Week Sports, Fishing and Cardinals Training Camp (based on schedule)	\$595	102	\$50	\$30 depart \$30 return
Aug 16-23	Sat. 9am- Sat. 4pm	Girl's Week Makeovers	\$595	102	\$50	\$30 depart \$30 return
Sept 20-27	Sat. 9am- Sat. 4pm	Grand Canyon Railways	\$595	102	\$50	\$30 depart \$30 return

Instructions to apply for Camp:

1. Parent and/or guardian must complete the entire application; leaving no blank spaces, along with \$50.00 deposit per session. Medical forms and releases must accompany application. All campers, returning or new must complete all forms.
2. If using respite, authorizations must be approved and in the office before attending camp.

IMPORTANT: Camper will not be fully registered until:

1. Application is signed, completed and received by the Camp Civitan office with the \$50 deposit enclosed for each session.
2. You will receive written confirmation from the Camp Civitan office. Contact us if acceptance/confirmation letter is not received within 3 weeks. **Please do not assume acceptance.** Written confirmation is the only verification acceptable.
3. You have sent Medical Form and Copy of medical insurance card is attached to the page provided with the medical form.
4. Private pay campers must pay in full prior to attending session.
5. Parents/Guardians must contact their Support Coordinator to authorize respite hours to Civitan Foundation.
6. All DDD Authorizations are in the office.

MEDICATIONS: Applicants will not be allowed to attend camp unless: all medications, including vitamins are sent to camp **in daily pill binders for each dosages (breakfast, lunch, dinner, and bedtime...ETC.)**

accompanied with their original prescription bottle, and place in a Ziploc bag labeled with the camper's name and brought to check in. All medications must be listed on the medical form and approved by a physician. This will be enforced, and your applicants will not be able to board the bus if not received this way. Please call office for any questions regarding this new policy.

CAMP SESSION FEES: Private Pay fees are \$595.00 per session plus a \$50 activity fee. Campers requiring 1:1 supervision will have an added fee of \$200 for each week long session or \$100 for each weekend session. Decisions regarding 1:1 supervision are determined before camp during the applicant's evaluation meeting. (See pg. 4 for details)

REGISTRATION / DEPOSITS:

1. All applications, **INCLUDING DDD clients**, must enclose a \$50.00 deposit fee for each session. For private pay this fee will be applied to total due. For respite this fee will be applied to the activity fee.
2. Payment in full must be received no later than 3 weeks prior to the start of the camping session.
3. Applications must be received no later than 6 weeks prior to your camp session.
4. There will be a \$50 late filing fee for any registrations received after that date.
5. Full refunds will only be issued for cancellations made 2 weeks prior to the reserved camping session(s).
6. A partial refund of half of the amount paid will only be issued for cancellation during the 2 weeks prior to reserve session(s).
7. No refund will be issued for cancellations requested at the start of the reserved camping sessions.
8. No refunds will be issued for any clients who are sent home due to – illness, behaviors, or homesickness.

Make checks payable to: The Civitan Foundation, Inc.

Please mail payment and all paper work to:

3509 E Shea Blvd., #117 Phoenix, AZ 85028

All correspondences should be done with the main office using the following methods:

Phone: (602) 953-2944, Camp Director Cell (602)402-6081 Fax: (602)953-2946

Or E-mail: info@campcivitan.org

Transportation: Charter bus transportation is available for \$60.00 round-trip per person. This service is limited and fills up quickly. Please send transportation fee with initial deposit to ensure a confirmed reservation.

CHECK IN: PHOENIX 7:30-8:30AM SATURDAY

RETURN TIME TO PHOENIX 4:00PM SATURDAY

CHECK IN: WILLIAMS (CAMP CIVITAN) after 2:00PM

PICK UP TIME AT CAMP CIVITAN on or before

11:00AM

SCHOLARSHIPS: Need-based financial assistance may be available, contact office for information and applications.

IMPORTANT MAILING INFORMATION - APPLICATION AND MEDICAL FORMS

Civitan Foundation 3509 E. Shea Blvd., Suite 117, Phoenix, AZ 8502

MUST
 Attach
 Recent
 Photo

2008 CIVITAN FOUNDATION PARTICIPANT FORM

PLEASE CHECK THE PROGRAM YOU WILL BE PARTICIPATING

Camp Civitan Phoenix Metro Scottsdale South Mountain Chandler Sun City/Surprise
 Glendale/Peoria Avondale Other _____

**PLEASE CHECK ALL BOXES THAT PERTAIN TO PARTICIPANT
 SEIZURES DIABETIC FOOD ALLERGY BEE STINGS**

OFFICE USE ONLY		
SESSION: _____	DEPOSIT RECEIVED: _____	MEDICAL RECEIVED _____
T-SHIRT SIZE: _____	BUNK BED: _____	FOOD ALLERGY: _____

All spaces must be filled in on this application. Incomplete applications will be returned. Put "NA" (not applicable), if information does not relate to camper's needs.

Participant's name: _____ DOB: _____ M: ___ F: ___
 Address: _____ City/State: _____ Zip: _____
 Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____ Participant Age: _____
 Distinguishing Marks or Features: _____ # of years he/she has attended Camp Civitan: _____
 First & Last Name of Person Participant lives with: _____ Relationship to Participant: _____
 Phone # _____ (cell) _____ (work) _____
 First & Last Name of Custodial Parent/Guardian: _____ Cell: (____) _____
 Custodial Parent-Home Address: _____ Home Phone: (____) _____
 Custodial Parent-Work/Business Address: _____ Work Phone: (____) _____
 Custodial Parent-EMAIL ADDRESS: IMPORTANT – Print Clearly: _____
 Alternate Emergency Contact: _____ Phone # _____ (cell) _____
 Relationship to Participant: _____

PERSON RESPONSIBLE FOR DROPPING OFF/PICKING UP PARTICIPANT:

NAME: _____ PHONE: _____

DDD RESPITE CLIENTS: DDD District: _____ Support Coordinator: _____

Phone (____) _____ Ext. _____ I, the Parent/Guardian, will arrange authorization with the support coordinator.

If DDD does not authorize hours for camp fees, I understand that I am fully responsible for the total of all camp fees.

SIGNATURE _____ DATE _____

BUNK BED CHOICE (PHYSICAL /MEDICAL NEEDS ARE ADDRESSED FIRST)

UPPER BUNK LOWER BUNK T-shirt size Sm Med Lrg Xlrg 2xlg 3xlg

INSURANCE INFORMATION

Insurance Card (copy) must be included with packet!

Name of Insurance co: _____ Policy # _____

Name of policy holder: _____ Relationship: _____

Participant: _____ Date: _____

First & Last Name of Second Parent/Guardian: _____ Cell: (____) _____
 Second Parent-Home Address: _____ Home Phone: (____) _____
 Second Parent-Work/Business Name: _____ Work Phone: (____) _____
 Second Parent-Work/Business Address: _____ Work Phone: (____) _____
 Second Parent-EMAIL ADDRESS: IMPORTANT – Print Clearly: _____

1. Likes and Dislikes:

2. Behaviors: Does the participant have any unusual behaviors that staff needs to be aware of during the trip? Yes No

If yes, please describe: _____

Can you give us any tips for managing those behaviors? _____

3. Fears Are there fears the participant has? Yes No If yes, please describe _____

4. 1:1 Supervision

These situations may require (but are not limited to) 1:1 Supervision, assistance with:

1. Toileting 2. Wandering 3. Behaviors 4. Eating

Does your child receive 1:1 supervision or assistance at school or program Yes No: _____

Does he/she have history of falling? Yes No _____

Does he/she need assistances walking up/down stairs? Yes No _____

Does he/she need 1:1 supervision due to wandering? Yes No: _____

Does he/she need assistance with toileting? Yes No _____

Does he/she need assistance with eating? Yes No _____

Please Describe Campers Disability List Diagnosis: (i.e., Mild Developmental Delay, Moderate, Severe, Autism, ADHD etc.)Add comments: _____

Does camper have any implants ie, Vagas Nerve Stimulator? Yes / No Explain _____

Does camper Require Special Medical Treatments? _____

Cerebral Palsy _____ Uses Wheelchair _____ % or time Uses Walker _____ Needs Help

Walking _____ Blind _____ Limited Vision _____ Wears Glasses/Contacts _____ Type _____

Diabetes: Yes / No Type _____ Insulin dependent: Yes / No: Does own blood sugars Yes / No

Heart Condition (type) _____

Easily Fatigued: Yes / No Asthma: Yes / No Inhaler: Yes / No Breathing Machine: Yes / No Deaf:

Yes / No Hearing Impaired: Yes / No Wears Hearing Aid: Yes / No False Teeth: Yes / No

Insect Sensitivity: Yes / No Type _____ Sun Sensitive: Yes / No Easily Overheated: Yes / No

Imagines Illness/Pain _____

Overly Tolerant of Pain _____ Other _____

Participant: _____ Date: _____

Describe in detail all camp or activities in which camper cannot participate. _____

Does camper tend to wander? Yes / No _____

Has camper ever run away from Home/School? Yes / No _____

Does camper have self-injurious behavior? Yes / No (Explain) _____

Is camper aggressive to others? Yes / No (Explain) _____

Does camper have unusual fears? Yes / No (Explain) _____

Does camper self stimulate? Yes / No (Explain) _____

How do you deal with these behaviors? Please describe positive reinforcements, and things or activities that calm or reward camper. _____

Is camper sexually active? Yes / No / Unsure Does camper use birth control? Yes / No

Has camper had any history or inappropriate sexual behavior? Yes / No (Explain) _____

Is a BEHAVIOR MANAGEMENT plan/program being used with camper? Yes / No If yes, you must send copy.

Camp Civitan provides three healthy nutritional meals and snacks daily. If your applicant requires special foods and or meals we ask that you pack all foods that your camper will need while at camp, along with detailed menus and explanation of preparations in detail. We will make every effort to comply and prepare what is sent. Please be sure to send enough for the length of stay at camp. We are able to adhere to food allergies, with proper notification.

Food Allergies: Please list all food allergies: _____

Meal Information: : Appetite is generally: (Circle) Excellent – Average – Fair – Poor

MEALS AT CAMP OR ON TRIPS:

Appetite is generally: (Circle) Excellent – Average – Fair – Poor

Requires limited portions: Yes / No, Explain _____

Special Diet: Yes / No, Explain _____

Do they need assistance eating or need special utensils? Adaptive equipment? Bibs? Utensils?
 Yes No If yes, please describe: _____

Are there any foods the participant is not allowed to eat? Yes No If yes, please describe _____

Participant: _____ Date: _____

SLEEP HABITS: (Circle and add comments)

Nightmares: Yes / No _____
 Afraid of dark: Yes / No _____
 Sleepwalks or wanders at night: Yes / No _____
 Restless or light sleeper: Yes / No _____
 Takes regular naps during day: Yes / No _____
 Does camper sleep through the night: Yes / No _____
 Has camper slept away from home before with other family or friends: Yes / No _____
 Does camper use any medical device or machine for sleeping i.e. IPAC Yes / No Explain _____

SKILLS (Circle and describe)

Beginning reader Yes / No _____
 Carries on clear conversation Yes / No _____
 Camper may be difficult to understand Yes / No _____
 Limited speech Yes / No _____
 Is Non-Verbal Yes / No _____
 Understands simple speech Yes / No _____
 Uses ASL or simple signs Yes / No _____
 Simple chores Yes / No _____
 Wishes work experience Yes / No _____
 What are camper's favorite activities at home or play _____

CAMPERS DRESSING SKILLS: (Circle and describe)

Camper fully dresses self without assistance Yes / No _____
 Camper needs minimal assistance Yes / No _____
 Camper mostly dresses with verbal prompts Yes / No _____
 Camper needs full assistance to dress Yes / No _____

TOILETING SKILLS: (Circle and describe)

Camper totally takes care of own toileting Yes / No _____
 Habit trained on regular schedule Yes / No _____
 Does camper wet bed Yes / No If yes, how often, _____
 Is camper easily constipated Yes / No _____
 Had problems with diarrhea Yes / No _____
 Does camper wear diapers or pull-ups Yes / No Day _____ and / or Night _____ If so, please send enough for your camper's needs.
 Does camper need assistance Yes / No Explain _____
 Does camper use toilet during the night Yes / No _____
 Does camper shave self: Yes / No / doesn't apply _____ Electric or Safety razor (circle) _____
 Needs assistance with menstrual needs Yes / No doesn't apply _____
 Is camper familiar with shower Yes / No If no, Explain _____

CURRENT SWIM LEVEL: (please check)

None _____ Wading _____ Beginning _____ Intermediate _____ Advanced (deep-end dives) _____

Camper may participate in supervised swimming activities: Yes / No _____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

Please give us any other information that you think would be helpful to us while we are out in the community with your son/daughter. Remember, we are trying to make this experience as enjoyable as possible for the participant, so giving us as much information as you can would be much appreciated. Attach additional paper as needed.

Participant: _____ Date: _____

Please read each, initial each and sign below.

Photos/Media: I hereby give my consent for (camper's name) _____ to attend Civitan Foundation Programs. I also grant permission to the Civitan Foundation, Inc. to use likeness, voice, words of the participant in TV, newspaper, film/video, or other media, for the purpose of promoting the Civitan Foundation, Inc. programs.

Please initial: _____

Search and Seizure: As a condition of participation and in order to provide a safe environment for all campers, Civitan Foundation adopts a policy of reasonable search and seizures of the person and of personal property in situations of suspected theft, illegal drugs, or possession of contraband items such as weapons, fireworks or alcohol. Your signature is deemed as written consent to such reasonable searches and seizures and a waiver of all claims against Civitan Foundation, Inc.

Please initial: _____

Release: As a further condition to ensure the safety of all campers, I authorize Camp Civitan, its agents and employees, to call appropriate agencies, including Child Protection Services, law enforcement agencies, and mental health providers if (camper's name) _____ becomes violent or is a threat to his/her own safety or the safety of others.

Please initial: _____

Disclosure: I have fully disclosed (camper's entire name) _____'s health conditions, including any propensities towards violent behavior. I authorize Camp Civitan to share this information with their counseling staff.

Please initial: _____

Waiver of Responsibilities: The undersigned does hereby release and discharge Civitan Foundation, Inc. and any and all of its agents or affiliates, employees or servants from any and all claims, liabilities, demands or rights which I (we), or any friends or relatives, may have against said corporation, or any of its agents, affiliates, employees or servants on account of, connected with, or growing out of, any injury, accident, loss, damage or suffering, I (we) may hereafter sustain while on the premises or property owned, leased or used by Civitan Foundation, Inc., arising out of granting permission for camping and recreation programs or usage of the said premises, whether said property be known as Camp Civitan or any other named designation or location. I authorize the Civitan Foundation, Inc. staff to secure medical treatment if necessary in the event of an emergency.

Please initial: _____

Off Camp Trips: I agree and consent that on occasion my camper may leave the property of Camp Civitan if so authorized by the Director or persons in charge.

Please initial: _____

Camp Civitan is a camp for a special population; however we are not equipped to service individuals who are medically fragile with communicable diseases or technologically dependent persons. Due to the nature of Camp Civitan, we are unable to accommodate individuals with psychological, emotional, conduct disorders, or anyone exhibiting aggressive tendencies. In making a final selection of clients, the Director reserves the right to take into consideration the needs of the applicant, the other clients, the expertise of the Staff. Each camping session will be balanced to best accommodate our clients' needs. The Camp Director, based on past experience or recent evaluation, may request that a personal attendant (supplied by the client) accompany any client for their stay at the camp. This attendant must adhere and follow all camp policies and meet with the director prior to camp. Additional fees will be assessed. This will be considered on a case by case situation.

Please initial: _____

I have read and understand the above statements. If the need arises to pick up my camper prior to the end of his camping session, I agree to promptly pick up my camper from the camp.

Please initial: _____

Send completed CAMPER APPLICATION to: Camp Civitan, 3509 E. Shea Blvd., Suite 117, Phoenix, AZ 85028. DO NOT SEND APPLICATION OR MED FORM BY SPECIAL DELIVERY TYPE MAIL OR OVERNIGHT MAIL. This type of mail delivery is sometimes delayed. The MEDICAL FORM should be sent in AFTER camper has exam, and doctor has completed form. Send to address above.

Participant: _____ Date: _____

Household/Demographic Information: The household and demographic information is required for federal funding and reporting purposes only. This information provided will not affect eligibility for camp.

Total number of persons living in household: _____ Is applicant disabled Yes No
 Is applicant a female head of household Yes No Age of applicant _____ Male: _____ Female: _____

Mark the number of persons living in your household and on the same line marked your total annual household income.
(Combined gross annual income of all persons in the house regardless of whether they assist with household expenses)
(Complete this box) (Check off your income in one of these boxes)

Total No. of Persons Living in Household	Total Combined Household Annual Income	Total Combined Household Annual Income	Total Combined Household Annual Income	Total Combined Household Annual Income
Check one	Less Than Check one	Less Than Check one	Less Than Check one	MORE Than Check one
1	\$12,150	\$20,250	\$32,400	\$32,400
2	\$13,900	\$23,150	\$37,050	\$37,050
3	\$15,650	\$26,050	\$41,700	\$41,700
4	\$17,350	\$28,950	\$46,300	\$46,300
5	\$18,750	\$31,250	\$50,000	\$50,000
6	\$20,150	\$33,600	\$53,750	\$53,750
7	\$21,550	\$35,900	\$57,450	\$57,450
8	\$22,950	\$38,200	\$61,150	\$61,150
9	\$24,300	\$40,550	\$64,850	\$64,850
10	\$25,700	\$42,850	\$68,550	\$68,550

Race: Caucasian Black/African American Asian American Indian/Alaskan Native Hawaiian/Pacific Islander
 Hispanic/Latino Asian/Caucasian American Indian/Caucasian Black/African American/Caucasian American Indian/Alaskan Native & Black Other _____ Residence city: _____ Zip Code _____

ACCEPTANCE CONDITIONS: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND SIGN YOUR NAME BELOW.

Camp Civitan does not discriminate on the basis of race, color, religion, sex or sexual orientation.
 Camp Civitan reserves the right to refuse to provide services to any individual when the camp staff determines that the individual cannot be provided with adequate support by Camp Civitan. These decisions are made on an individual basis, by the Camp Director or Executive Director. Parents, care-providers, and the DDD Support Coordinator (or other appropriate agencies) will be notified in the event of any serious injury or illness requiring more than basic first aid, or in the case of any significant incident or behavioral problem. The separate Health Information Form, signed by a physician, M.D., must indicate that there is no evidence of any condition that might present health or safety risks to the applicant, or to other campers or staff members.

Please do not assume your camper is confirmed until you receive a WRITTEN letter of confirmation. Your camper is NOT CONFIRMED until you receive a written confirmation either by email or mail. IF YOU DO NOT RECEIVE A WRITTEN CONFIRMATION or hear from us within 3 weeks of the Camp Session, please contact us. Please note that there may be times when we cannot place camper in your selected sessions. If it becomes necessary for Camp Civitan to choose an alternate date, we will contact you as soon as possible.

While he/she is at camp, I agree and consent that on occasion, my camper may leave the property of Camp Civitan if so authorized by the Camp Director or persons in charge. Further, I agree that my camper may be photographed while participating in the program of Camp Civitan with the understanding that such photographs may be used for publicity purposes. This authorization shall continue to be in effect as long as my camper is a participant in the program of Camp Civitan.

I agree to the Acceptance Conditions above. Should it become necessary for my camper(s) to leave camp, or any Camp Civitan function, for any reason, I will make provisions to bring the camper(s) home. I hereby certify that to the best of my knowledge, all of the information contained in the application is true and complete. I hereby authorize the release of any and all pertinent information regarding this camper to Camp Civitan. I agree to notify Camp Civitan with any changes that need to be made in this application before camp.

Signature _____ Relationship to Camper _____ Date _____

CAMP CIVITAN 2008
NEW MEDICAL FORM INSTRUCTIONS:

Directions for Health History Form:

1. Form A of health packet, caretaker completes and signs. All lines must be completely filled out. Put “NA” if not applicable. (2 Pages)
2. Form B of health packet must be completed by camper’s physician.

The camper’s physician must complete and sign a **NEW** medical form EACH YEAR. However, the actual exam (check-up) can be within 12 months of camp time. This medical form **MUST** be sent in by due dates . Please call your physician **EARLY**. Sometimes “physical exams” need to be booked months in advance, especially if you have AHCCCS, HMO or a PPO.

Please return forms A & B prior to due dates.

3. Parents/Caregivers must take responsibility to pick up the medical form from the doctor’s office and mail or fax **BEFORE THE DUE DATE** with the copy of the medical insurance card at the same time. DO NOT USE OVERNIGHT MAIL FOR DELIVERIES. Often, this type of mail is delayed if we are unable to be in the office to sign.
4. **MAILING INFORMATION: PARENTS MUST MAIL MEDICAL FORM AND COPY OF MEDICAL INSURANCE CARD DIRECTLY TO CIVITAN FOUNDATION, INC at the same time. DO NOT HAVE YOUR PHYSICIAN FAX FORM.** Allow plenty of time for picking up and mailing form. If your camper is confirmed for a certain session, and you do not get the medical form in on time, your camper will lose his space on that session. Mail form to Civitan Foundation, Inc., 3509 E. Shea Blvd, Suite 117, Phoenix, AZ 85028.
5. You should **ALWAYS** keep a copy of this completed application form for your records; some do get lost in the mail.

Instructions for Medications:

- Medications, including vitamins and supplements must be sent in individual daily pill binders, for each dosage given. That is one for morning meds, lunch meds, dinner meds, and bedtime meds.
- **ALL medications, vitamins and supplements MUST BE LISTED** on the medical form and approved and signed off by the physician.
- **All medications MUST be given at check-in before departure. Place all pill binders and original bottles in a Ziploc gallon bag with camper’s name on it.**
- If camper must take medication while on the bus trip to camp, place that dose of medicine in a separate sealed envelope or bag (with camper’s name). Please be sure to advise staff at check-in.
- **DO NOT PLACE ANY MEDICATIONS IN CAMPER’S BACKPACK OR LUGGAGE.**
- Due to strict legal policies, the camp staff **CANNOT** give your camper any medications unless they are packed as instructed above.

PLEASE BE SURE TO PACK ENOUGH MEDICATION for the entire session.

Please note: all medications will be packed in returning luggage.

**Medical History & Exam
 Form A- Section 1
 Parent/Guardian completes**

Parent/Guardian or Primary Caregiver completes

Participant's Name: First _____ M.I. _____ Last _____

Address: _____ City/State: _____

Parent/Guardian: _____ Email: _____

Phone#: _____ (cell#) _____

Person Camper lives with: _____ Camper's Age _____ Date of Birth: _____

Emergency Contact: _____

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

MEDICAL INFORMATION

Health History:

Bleeding Problem	Yes	No	Recent contagious Disease or Febrile illness or Hepatitis	Yes	No
Dentures/False Teeth	Yes	No	Head injury	Yes	No
Hearing Problems	Yes	No	Kidney Problems	Yes	No
Diabetes	Yes	No	Requiring Special Equipment	Yes	No
Fainting Spells	Yes	No	Bone or joint Problems	Yes	No
Emotional Problems	Yes	No	Heart Problems	Yes	No
Special Diet needs	Yes	No	Heat Illness or Cold injury	Yes	No

PARTICIPANT'S PRIMARY DISABILITY / DIAGNOSIS

- | | | | |
|--|--------------------------|--|-------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. Autism | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Heart Condition |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Mental Retardation |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Cerebral Palsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Behavioral Disorder |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Spinal Bifida | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Learning Disability |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Muscular Dystrophy | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Hearing Impairment |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Visual Impairment |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Spinal Cord Injury | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Mental Illness |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Stroke / Brain Injury | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Other _____ |

Seizure History: Describe Seizures (type and frequency) _____

Last Seizure date _____ what should our response be to the seizures Examples: If they seize for more than 3 mins., we need to call an ambulance...if they need to nap after seizure, let nap for 2 hrs.... _____

Participant: _____ Date: _____

Health History: (List details, approximate dates for conditions like frequent ear infections, heart defect/disease, convulsions, diabetes, bleeding/clotting disorders, hypertension, and diseases such as mononucleosis, etc.): _____

Allergies: _____

Restricted Activities: _____

IMPORTANT: If your camper must take medications, vitamins or supplements while at camp, they **MUST** be listed on this form and be reviewed by his/her physician. **All medications MUST be given at check-in before departure. Place all pill binders and original bottles in a Ziploc gallon bag with camper's name on it.**

If camper must take medication while on the bus trip to camp, place that dose of medicine in a separate sealed envelope or bag (with camper's name). Please be sure to advise staff at check-in.

Insurance Card (copy) must be included with packet!

Insurance Name: _____ Policy # _____

I, the undersigned, hereby represent that I am the parent or legal guardian of this participant, and state the health history is correct so far as I know. I agree that he/she may participate in the program of Civitan Foundation Inc. I consent that in the event of sickness or accidents, Civitan Foundation will not be held liable. With the realization that in such eventuality personal notification may not be possible, I authorize Civitan Foundation to render any aid and assistance to help my participant, to call a physician or medical help if necessary, who may take any measure necessary to help my participant. I give the staff of Civitan Foundation permission to give medication to the participant. I agree to pay for any prescribed medication or treatment my participant may need.

Signature of Parent/Guardian _____ Date _____

Participant: _____ Date: _____

Doctors Name: _____ Phone #: _____

Address: _____ City/State/Zip: _____

Section 2: Physician's Report

Participant Name: _____ Date of Exam: _____

Height: _____ Weight: _____ Temp: _____ Pulse: _____ Resp.: _____ B/P: _____

Date of last immunizations:

Immunization History	
TB (PPD) Screening date: _____	Results: _____
Hepatitis - B Screening date: _____	Results: _____
Hepatitis - B Vaccination: _____	Chicken Pox _____
Tetanus date: _____	DPT date: _____
MMR date: _____	DPT date: _____
Polio dates: _____	

	Normal	Abnormal (describe)		Normal	Abnormal (describe)
Eyes			Cardio-Vascular		
Ears			Reparatory		
Nose			Abdominal		
Throat/Mouth			Neurological		
Skin			Musculoskeletal		

Current Medication Name	Dosage(how much)	Frequency: Times of day given	What is medication for

Participant: _____ Date: _____

Recent Health Problems: _____

Other pertinent Diagnoses and/or current treatment: _____

Any prescribed meal plan or dietary restrictions: _____

Statement of Physician: I have examined participant_____. I have found no evidence of communicable disease and found him/her to be in satisfactory condition to participate in camp programs to:

A: _____ full extent without restrictions
B: _____ limited extent. Conditions as follows: _____

Signature of Physician: _____ Date: _____

Camp Civitan Standing Orders for Over the Counter Medications

Camp Civitan will not administer any over the counter medications unless this form has been filled out by your
 health provider

The Arizona State Department of Health is requiring that summer camps have an individualized set of standing orders for each attending camper. These standing orders specify which over-the-counter medications may be administered to an individual camper and under what conditions. This form pertains to only over-the-counter medications, and must be completed and signed by a physician, physician's assistant, or nurse practitioner. Medications must come with campers in original bottles and containers. We will not have these medications available at camp.

In case of medical emergencies we will contact 911 or transport to the nearest urgent care facility or hospital.

INDIVIDUALIZED ORDERS FOR: **NAME:** _____

Age: _____ **Weight:** _____

Drug Name	Route (Please circle preferred)	Dosage	Schedule and Indications	Camper Health-Care Provider Order	Comments
Tylenol (Acetaminophen)	PO (Chewable tabs, elixir)	Per Label Instructions by age/ weight	Q 4 hr prn for pain Or fever > ___°F	Yes No	
Motrin (Ibuprofen)	PO (Chewable tabs, sus-)	Per Label Instructions by age/ weight	Q 6 hr prn for pain Or fever > ___°F	Yes No	
Robitussin (Guaifenesin)	PO (Syrup)	Per Label Instructions by age/ weight	Q 4 hr prn for Cough	Yes No	
Mylanta	PO (Chewable tabs, Liq-)	Per Label Instructions by age/ weight	TID-QID prn for Stomach upset	Yes No	
Tums	PO (Chewable Tabs)	Per Label Instructions by age/ weight	BID-TID prn for Stomach upset	Yes No	
Dimetapp	PO (Liquid)	Per Label Instructions by age/ weight	Q 6-8 hr prn for Nasal congestion/drainage	Yes No	
Benadryl (Diphenhydramine HCL)	PO (Elixir or tabs)	Per Label Instructions by age/ weight	Q 4-6 hr prn for Allergy	Yes No	
Midol	PO (Chewable tabs)	Per Label Instructions by age/ weight	Q 4-6 hr prn for menstrual symptoms	Yes No	
Imodium AD (Loperamid)	PO (Tabs)	Per Label Instructions by age/ weight	1 caplet after 1 st BM, and 1/2 caplet after each subsequent loose BM	Yes No	
Sudafed (Pseudoephedrine)	PO (Tabs)	Per Label Instructions by age/ weight	Q 4-6 hr prn for nasal decongestant	Yes No	
Other					

Doctors Name _____ Phone # _____

Signature _____ Date _____