PARTICIPANT APPLICATION FORM

Thank you for your interest in Camp Without Borders! Please carefully read and complete all areas of the application form. Applications must be submitted by the deadline to be considered.

PARTICIPANT INFORMATION

Which trip or day program are you applying for? ____

First Name ______________________________ Last Name ____________________________

Nickname/ Preferred Name ____________________________

Address ____

Birthday (mm/dd/yy) ______________________ Phone# ______________________________

Email ________________________________ Primary Language _______________________

What is your living arrangement? ____

Are you legally under the care of a guardian(s)? ☐ Yes ☐ No

If under guardianship, please provide guardian's information.

Name ______________________________ Relationship to applicant _______________________

Address ____

Primary # ____________________________ Alternate # ______________________________

Who is completing this application? ☐ Participant ☐ Other

If other, please provide the name and relationship to the applicant.

Name ______________________________ Relationship to applicant _______________________

How did you hear about Camp Without Borders? ____

How will you get to and from our meeting or activity location?
☐ Access Transportation: Access ID No. ____________ ☐ DART: DART ID No. _____________
☐ Other Public transportation ☐ Drive my own vehicle
☐ Ride By whom ______________________

EMERGENCY CONTACT

Please provide TWO individuals (other than the guardian listed above), Needs of the Community Society via Camp Without Borders may contact or turn the participant over to, in case of an emergency.

Name________________________________ Relationship to applicant________________________

Primary #_______________________________ Alternate # ______________________________

Name________________________________ Relationship to applicant________________________

Primary #_______________________________ Alternate # ______________________________

MEDICAL INFORMATION

Primary Physician__________________________________ Phone#___________________________

Physician Address____

Primary Diagnosis____

Secondary Diagnosis____

Insurance Provider_______________________________ Insurance #_______________________

TREATMENT RECORD

	Most recent date	Reason	# Of visits the past 12 months
Doctor			
Emergency			
Hospitalization			
Surgery			

GENERAL MEDICAL HISTORY

Please check all of the applicable medical conditions.

- ☐ ADD/ ADHD
- ☐ Appendicitis
- ☐ Asthma

Severity:
☐Mild ☐Moderate ☐Severe
Do you require an inhaler? ☐Yes ☐No

- ☐ Hay Fever/ Seasonal allergies
- ☐ Heart condition
- ☐ Hepatitis
- ☐ Hypertension

- ☐ Anxiety
- ☐ Bronchitis
- ☐ Car/ Motion Sickness
- ☐ Constipation
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Ear infections
- ☐ Eczema/ Rash
- ☐ Epilepsy
- ☐ Frequent Colds
- ☐ Fainting
- ☐ Other condition(s)

- ☐ Immunodeficiency
- ☐ Kidney or Urinary Tract Infections
- ☐ Measles
- ☐ Headaches/ Migraines
- ☐ Mumps
- ☐ Seizure

Date of last seizure______________________
Type__________________________________
Frequency_____________________________

- ☐ German measles

Please specify____

ANATOMY/ DEVICES

Please check all the applicable anatomy/ devices.

- ☐ Wheelchair
- ☐ Splint/ Brace
- ☐ Contacts
- ☐ J-pouch
- ☐ Ostomy
- ☐ Crutches/ Cane
- ☐ Artificial limb
- ☐ CPAP
- ☐ G-Tube
- ☐ Feeding tube
- ☐ Walker
- ☐ Glasses
- ☐ Insulin pump
- ☐ Oxygen

☐ Other____

ALLERGIES

☐ NONE

	ITEM(S)	TYPICAL REACTION	TREATMENT
MEDICATION			
FOOD			
OTHER			

CURRENT MEDICATION SCHEDULE

Please list all medications and supplements, including over the counter items, with as much details on this form.

NAME	STRENGTH/CONC.	BREAKFAST	LUNCH	DINNER	BEDTIME
EXAMPLE DRUGE A	*10MG*	*1 PILL 10AM ON EMPTY STOMACH*	*1 PILL WITH LUNCH AROUND 1PM*	*1 PILL WITH FOOD NO LATER THAN 7PM*	*2 PILLS PRIOR TO BED*

Please provide any additional information or directions if required.

LEVEL OF ACTIVITY

Can you comfortably walk 4 city blocks without requiring rest? ☐Yes ☐No
Please provide any additional information or comments.

____

____

____

____

LEVEL OF ASSISTANCE

Do you require 1:1 support: ☐All day ☐Parts of the day ☐No

Please check all the appropriate boxes.

	Independent	Require Reminders	Moderate Assistance	1:1
Daily Care (ie. Dressing, brushing teeth)	☐	☐	☐	☐
Bathing/ Showering	☐	☐	☐	☐
Meals	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Medication Intake	☐	☐	☐	☐

Please provide any additional information or comments.

PARTICIPANT PROFILE

Past travel, camp and away experiences:
☐ Little to no experience away
☐ Been away before
☐ Frequent

What is the longest length of time away? ________________________________

Please share some of your travel experiences.

____

Please briefly describe your personality.

____

____

____

BEDTIME

Please indicate any concerns.

☐ Difficulty walking
☐ Fear of dark
☐ Snoring
☐ Bedwetting
☐ Sleep walking
☐ Talks in sleep
☐ Nightmares
☐ Difficulty falling asleep

☐ Other____

Please provide any additional information, comments and helpful routines that are helpful.

____

____

____

BEHAVIOR

Please indicate all applicable behaviors.

☐ Punching/ Hitting
☐ Running
☐ Self injurious behavior
☐ Sensitivity to noise
☐ Homesickness
☐ Require high level of attention
☐ Risk to others
☐ Easily frustrated
☐ Drugs and Alcohol

☐ Other____

What causes the behavior(s) indicated above? Please be as specific as possible.

____

____

____

What methods/ techniques help de-escalate, re-direct or prevent this behavior?

____

____

____

____

FOOD/ DIET

Please describe your eating habits.

☐ Selective ☐ Average ☐ Easy

What is your favorite meal?____

Do you have any dietary restrictions? ☐ Yes ☐ No

If yes, please provide your restrictions.

____

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PHOTOGRAPHIC RELEASE

I consent and authorize Needs of the Community Society via Camp Without Borders to take photos and/or videos of the above name participant during activities. I understand that the resulting materials may be used for purposes of travel, identification and for distribution or informational presentations about Needs of the Community Society and Camp Without Borders on our website and brochures.

____________ Initial here if you **DO NOT** consent to the photographic release.

Thank you for your application. Please submit your completed form to zac.gannett@nocsociety.org