

## 2020 Schedule

### **Handi-Camp 1 ..... May 26-29**

\$225.00 (\$245.00 after May 1) Registration for this camp closes on May 12.

Check in Tuesday at 1:00 pm Eastern, Check-Out Friday at 10:30 am Eastern

### **Handi-Camp 2 ..... July 27-30**

\$225.00 (\$245.00 after May 1) Registration for this camp closes on July 13.

Check in Monday at 1:00 pm Eastern, Check-Out Thursday at 10:30 am Eastern

### Instructions for Completing Registration Form:

1. Complete the entire registration form. This is essential to determine the level of care that will be required for each camper. Feel free to provide additional information if necessary.
2. A deposit of \$100.00 must be sent with the registration form. Forms without the deposit will not be processed. Remaining balance is due 2 weeks prior to the first day of your camp session. If the funds are coming from a secondary source, please indicate that on the registration form.
3. We do not provide transportation to or from camp. Transportation is to be arranged through the caregiver or guardian.
4. Send the completed registration form and deposit to:

White Mills Christian Camp

P.O. Box 129

White Mills, KY 42788

Questions? You can reach us at 270-862-3933

### Packing List

**Enough clean cloths for entire session.** Include underwear, daily clothing, night clothes & swimwear. An extra outfit is always a good idea.

**Bedding & pillows** (towels, personal care items, sunscreen, insect repellent)

**Adult Undergarments** if required by camper. Please bring enough for the entire session.

**Bible** if the camper has one.

**Medications:** All medications must be in original pharmacy container.

### **Please do not bring the following:**

Tobacco products, electronic smoking devices, alcoholic drinks, illegal drugs.

Electronic games, prank items, matches, lighters, fireworks

White Mills Christian Camp  
2020 Handi-Camp Registration Form

Please choose your camp session(s) May 26-29 \_\_\_\_\_ (deadline May 12)  
July 27-30 \_\_\_\_\_ (deadline July 13)

Cost: \$225.00 per session, \$245.00 after May 1

Camper Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Gender M F

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Shirt Size \_\_\_\_\_

Camper Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Disability \_\_\_\_\_ Wheelchair? Yes No

Church \_\_\_\_\_ First time camper? Yes No

Parent/Caregiver/Guardian Contact Information

Parent/Caregiver \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Best Contact Number \_\_\_\_\_

Email \_\_\_\_\_

Guardian \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Best Contact Number \_\_\_\_\_

Email \_\_\_\_\_

Emergency Contacts

Please list (in order) the person we should call in the event of a medical, behavior, or other emergency.

1. Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

3. Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

MEDICAL INFORMATION

All medications will be turned over to the medical staff at the time that Campers are checked in. All medications (including non-prescription) will be dispensed by the designated member of that staff. All medications are to be in original pharmacy-labeled medication containers. **Please list required medications below or include an up-to-date MAR sheet with this registration form.**

Medication \_\_\_\_\_ Dosage/Frequency \_\_\_\_\_

Medication \_\_\_\_\_ Dosage/Frequency \_\_\_\_\_

Medication \_\_\_\_\_ Dosage/Frequency \_\_\_\_\_

Medication \_\_\_\_\_ Dosage/Frequency \_\_\_\_\_

Medication \_\_\_\_\_ Dosage/Frequency \_\_\_\_\_

Medication \_\_\_\_\_ Dosage/Frequency \_\_\_\_\_

Best person to call regarding medication questions: \_\_\_\_\_

Does this camper require additional treatments or devices that must be administered by a qualified medical staff person (feeding tube, catheter, etc.) Please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does this camper have seizures? \_\_\_\_\_

Type & Frequency \_\_\_\_\_ Date of Last Seizure \_\_\_\_\_

Please list any food allergies or restrictions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list any other allergies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Mobility:** \_\_\_Independent \_\_\_Assistance \_\_\_Walker \_\_\_Wheelchair \_\_\_Electric Wheelchair  
(For non-ambulatory campers it is the caregiver/parent/guardian to provide a wheelchair or other device that is safe and in optimum operating condition)

**Vision:** \_\_\_Normal \_\_\_Glasses \_\_\_Contacts \_\_\_Vision Impaired \_\_\_Legally Blind

**Hearing:** \_\_\_Normal \_\_\_Impaired \_\_\_Uses Hearing Aids (send batteries) \_\_\_Deaf

**Communication:** \_\_\_Verbal \_\_\_Speech Difficulty \_\_\_Nonverbal \_\_\_Signs  
\_\_\_Communication Board

**Disabilities (list all)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physical Disabilities** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Level of Care Required:**

**Personal Care:** \_\_\_Independent \_\_\_Requires Assistance \_\_\_Dependent

**Showering:** \_\_\_Independent \_\_\_Requires Assistance \_\_\_Dependent

**Toileting:** \_\_\_Uses Urinal/Toilet \_\_\_Uses Bedpan \_\_\_Catheterizes Self \_\_\_Must be Catheterized  
\_\_\_Wears "Depends" \_\_\_Prompts after toileting \_\_\_Assistance after toileting

Other: \_\_\_\_\_

**Mealtime:** \_\_\_Uses Utensils \_\_\_Uses fingers \_\_\_Special Container \_\_\_Requires Bib \_\_\_Uses Straw

Other: \_\_\_\_\_

**Nighttime:** \_\_\_Nighttime incontinence \_\_\_Wears "Depends" \_\_\_Gets up during night

Sleeps on: \_\_\_Back \_\_\_Stomach \_\_\_Right Side \_\_\_Left Side

Other considerations: \_\_\_\_\_

**Other Needs:** \_\_\_\_\_

Activities camper should not engage in: \_\_\_\_\_

Discipline/Inappropriate Behavior Concerns: \_\_\_\_\_  
\_\_\_\_\_

Special Interests/Skills: \_\_\_\_\_

**Reading Skill:** \_\_\_Yes \_\_\_No \_\_\_With Assistance **Writing Skill:** \_\_\_Yes \_\_\_No \_\_\_With Assistance

Other information that would be helpful to staff: \_\_\_\_\_  
\_\_\_\_\_

Has this individual ever been the victim of abuse? \_\_\_Yes \_\_\_No

Explain \_\_\_\_\_

Has this individual ever been charged with abuse or related misconduct? \_\_\_Yes \_\_\_No

Explain \_\_\_\_\_

# Camp Agreement

I certify that the information provided on the application is true and accurate to the best of my knowledge. I assume full responsibility for all property belonging to \_\_\_\_\_. I will not hold White Mills Christian Camp, or any Camp staff responsible for any damage to or loss of said property.

I request that White Mills Christian Camp obtain necessary emergency medical treatment for the above-named camper as needed. I understand that I, and /or my medical insurance provider will be responsible for all medical costs incurred for such emergency medical care required during the camp sessions indicated.

I hereby give permission for the above-named Camper to appear in photographs or video recordings made during the Camp sessions indicated. This permission also extends to the use of those photographs or video recordings in promotional presentations made by White Mills Christian Camp or its affiliates.

We take our obligation to provide appropriate care very seriously. Therefore, the information that you provide during the registration process is absolutely essential. Additional time for completion of the information gathering process is provided on the opening day of each Handi-Camp session. If, in the course of the Handi-Camp session, it is determined that crucial information has not been provided, such that appropriate care cannot be assured, this Camper will be required to return home immediately.

**Please Note:** We must be able to contact Parent, Guardian or Caregiver for the Camper named on this application at any time, day or night, for the duration of the Special Needs Camp session. If you, as the signer (below) will, at any time, be unable to respond to any communication regarding the Camper, you must provide an alternate contact person for the Special Needs Camp Coordinator to call. That person **must be able to contact you promptly.**

## Signature Required

\_\_\_\_\_ **Date** \_\_\_\_\_  
(Parent/Guardian/Caregiver)

\_\_\_\_\_ **Date** \_\_\_\_\_  
(Camper)

## Payment Information

A deposit of \$100.00 per camp is due at this time. Forms without the deposit will not be processed. The remaining balance is due 2 weeks prior to the first day of your camp session.

### Please choose one:

\_\_\_\_\_ The deposit is enclosed

\_\_\_\_\_ The entire camp fee is enclosed

\_\_\_\_\_ Payment will come from State Guardianship or another source. (Registration will be held until payment is received)

\_\_\_\_\_ I require an invoice. Please send to: \_\_\_\_\_

### Camp Office Only:

Amt. Due \_\_\_\_\_ Deposit Received \_\_\_\_\_ Balance Due \_\_\_\_\_

Invoice # \_\_\_\_\_