



Shepherds Camp 2019 Registration Form

Camper _____ Age _____ M F DOB ____/____/____
Address _____ Phone () _____ - _____
City _____ State _____ Zip _____ County _____

Adult T- Shirt Size: (Circle One) 3XL XXL XL L M S Nickname _____

Has the camper attended Arrowhead before? Yes No Last year attended: 2018 _____

PLEASE NOTE: NEW CAMPERS NEED TO SCHEDULE A MEETING WITH THE PROGRAM MANAGER

Care Provider _____
Home Phone () _____ - _____ Cell Phone () _____ - _____
Address _____ City _____ State _____ Zip _____
Care Provider E-mail address _____
Relationship to Camper: (FCP, parent, sibling, House Manager, etc.) _____

Please Check Program(s) Desired:

1 Week Programs \$545 / person
(Check out 10AM)

- Sunday June 2nd- Friday June 7th
- Sunday June 9th- Friday June 14th

Registration Fee: \$100.00 (non-refundable)
Remaining Balance: \$445.00 **Due May 23rd**

2 Week Programs \$1,095 / person
(Check out 10AM)

- Sunday June 2nd- Friday June 14th
- Sunday June 23rd - Friday July 5th
- Sunday July 21st - Friday August 2nd

Registration Fee: \$100.00 (non-refundable)
Remaining Balance: \$995.00 **Due May 23rd**

1 to 1 Week Programs \$1,095 / person
[open to campers who require individual care]

- Monday May 27th, Check in @ 10:30 AM - Friday May 31st, Check out @ 1:00 PM
- Monday June 17th, Check in @ 10:30 AM - Friday June 21st, Check out @ 1:00 PM
- Monday July 15th, Check in @ 10:30 AM - Friday July 19th, Check out @ 1:00 PM
- Monday Aug 5th, Check in @ 10:30 AM - Friday Aug 9th, Check out @ 1:00 PM

Please contact the main office today for information on Camper Scholarships!

Make check or money order payable to: Arrowhead Bible Camp
Mail to: Shepherds Camp, Arrowhead Bible Camp, 122 Arrowhead Cottage Rd., Brackney, PA 18812
Questions? Call - (570) 663-2419 Fax- (570) 663-2903 bkarrowhead@gmail.com www.shepherds-camp.org

Office Use Only

Rec'd: _____ M1: ___ M2: ___ PRN: ___ MA: ___ Amount: _____ Check #: _____ E: ___ C: ___

NOTE: While this camper may have attended camp in the past, his/her counselor for the session may be unfamiliar with them. Be thorough so staff can best understand and care for your individual's unique needs.

Activities of Daily Living:

	Independent	Assistance	Total Care	Please specify assistance required
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brushing Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Using Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Washing Hands and Face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tying Shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Menstruation (women only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Camper uses: Glasses Hearing Aids Dentures Orthopedic Device (explain in Mobility) Other: _____

Toileting & Overnight Care:

Camper requests to stay in: Cabin Dorm

Bunk with: _____

Do NOT bunk with: _____

Needs Bedrails

Uses CPAP/Oxygen Concentrator

Wets Bed: Never Occasionally Frequently

How is bed-wetting handled? _____

Wears Diapers: Never Nightly Daily Always

Uses Commode/Portable Urinal at Night

Sleeps through the night

Needs to be awakened to use the toilet

Hourly bed checks

Bowel Routine: _____

Other: _____

Mobility:

Walking: Normal Slow Unsteady No Walking

Cane(s) Walker No Stairs Prone to Wander

Wheelchair: Electric Manual Always Distance

Braces/Orthopedic Device: (Explain) _____

Transfer Assistance: Independent 1-Person Assist

2-Person Assist Hoyer Lift

Other: _____

Communication:

Verbal Speech Impaired Speech No Speech

Sign Language Communication Device/Book

Normal Hearing Hearing Impaired Deaf

Normal Sight Vision Impaired Legally Blind

Other: _____

Behavior:

Active Sedentary Excitable Passive Behaves Rebellious Participates Cooperative Stubborn

Quiet Loud In need of constant watching Independent Attention-Seeking Story-Teller

Follows Directions: circle Yes / No Needs Time to Process Needs Reminders/Cues Needs Physical Assistance

History of Aggression: circle Yes / No Verbal Physical against Peers/Staff Self-Injurious Other

If this camper has a behavior support plan, please provide a copy for camp staff.

What provokes or precedes the aggressive behavior? _____

What interventions correct the aggressive behavior? _____

Describe any fears the camper may have: _____

Describe the camper's personality on a typical day: _____

What assistance/prompts do you commonly give the camper: _____

History of inappropriate behavior to the opposite gender: _____

How does this camper act when upset or angry? _____

Other: _____

Physical / Medical Information:

Please enclose a completed medical/physical form with the Application/Registration Form.

NOTE: If you are unable to do so please state why and give **date that the physical is scheduled.**

Reason: _____ Date Scheduled: _____

Eating:

- Eats Independently Needs Assistance Eating Feeding Tube: _____
- Needs Food Cut-Up (quarter sized) Needs Food Chopped (dime sized) Needs Food Pureed Meat Cut *Only*
- Overeats PICA Uses Straw for Liquids No Straws May Take Food From Others Needs Verbal Prompts
- Specialized Adaptive Equipment (**must be brought along with camper**): _____
- Thickened Liquids: Nectar Honey Pudding
- Food Restrictions: _____

OPWDD Food Modifications:

- This camper is an OPWDD Individual and their diet must conform to the OPWDD Food Regulations
- Whole Diet 1" Pieces 1/2" Pieces 1/4" Pieces Ground Puree
- Eating Strategies: _____

Liquids: Thin Nectar Honey Pudding

Other: _____

Swimming: *Note: A Lifeguard is on duty at all times*

- Enjoys Water Fears Water
- Swims Independently No Swimming
- Needs 1:1 Supervision in Water
- Paddle Boats (Accompanied by Staff & Wearing Life Jacket at all times)
- Shallow End Swimming (0-4 feet deep)
- Deep End Swimming (over 6 feet deep)
- Must wear life jacket in shallow end
- Must wear life jacket in deep end

Other: _____

Program Information:

Favorite Activities: _____

Goals/Objectives being worked on: _____

Favorite Song: _____

Favorite Food: _____

Favorite Chore/Job: _____

Dislikes: _____

Attends School: Grade & School _____

Employed: Type & Location _____

Other: _____

Health:

Allergies: _____

- Obesity Diabetes Asthma Blood Clotting Disorder Seizures Frequent UTI Frequent Constipation
- Frequent Diarrhea Recent Illness/Injury/Hospitalization: _____
- Allergy to Bee Stings or Insect Bites? Describe Reaction & Treatment: _____

Does this camper sunburn easily? Yes No If Yes, list restrictions: _____

Should this camper avoid exertion due to heart or other health concerns? _____

Describe additional health concerns that may hinder this camper's participation: _____

Other: _____

Activity Restrictions:

Please review the following camp activities and determine whether this camper may participate. Contact the camp office with any questions. All activities are closely supervised and modified to fit the camper's individual ability level.

- | | | | |
|-------------------|--|--------------|--|
| Adaptive Archery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Basketball | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Volleyball | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nature Walks | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kickball | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fishing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hay Ride (No Hay) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bowling | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mini Golf | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bocce Ball | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pedal Carts | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9 Square | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Other: _____

**CONTACT INFORMATION- Campers will not be admitted without completed emergency contact
ALL INFORMATION BELOW NEEDS TO BE UPDATED AND RELAVENT AT CHECK-IN**

Emergency Contact Person - 24-hour coverage - Person other than primary care provider who will be contacted in the event that the camper needs to be picked up early from camp:

Name: _____ Relationship to Camper: _____ Phone: (____) ____ - _____

Other names/numbers: _____

Is the primary care provider planning to be away during the camp sessions?

No, the primary care provider will be the contact person during the camp session.

Yes, the primary care provider will be away during the camp session and has informed the 24-hour contact person listed above that they will be on call and responsible.

13. Permission/Medical Release/Authorization for Treatment

(The following must be signed by custodial parent/guardian, care provider, or camper if self-guardian)

A. I, as an individual, parent, guardian, or appointed representative of the individual, understand that Arrowhead Ministries, Inc., henceforth referred to as "AMI", takes reasonable efforts to operate and conduct activities in a safe and responsible manner. These recreational activities include but are not limited to those named in this registration packet. I understand that these activities and the actions or inactions of other program individuals involve certain inherent risks. I recognize these risks and agree to assume all liability for these risks by allowing the individual to attend AMI's camp and participate in such programs and activities. I hereby release, indemnify, and hold harmless AMI, its officers, agents, employees, and all others from all liability and damages for injury, illness, and or death sustained by the individual relating to or deriving in any way from participation in aforementioned programs and activities, whether arising from an act of omission to the fullest extent permitted by law.

B. I, as an individual, parent, guardian, or appointed representative of the individual, understand AMI generally provides supervision of the individual in a 5:1 individual to staff ratio for all programs and activities, unless 1:1 is specified.

C. I, as an individual, parent, guardian, or appointed representative of the individual, hereby certify that I will accept emergency care offered by AMI for injury or illness. I hereby acknowledge that the designated first aid person/hospital in charge may perform emergency care and I hereby grant permission to AMI to release any medical information required by said parties and do hereby give permission for treatment. I understand that medical care will be provided according to the standard set forth by the Commonwealth of Pennsylvania and said designated first aid person is protected under the Good Samaritan Act. I acknowledge that all medications will be administered by AMI's nurse and hereby consent to treatment for minor illnesses as deemed necessary. I hereby give my permission to the medical personnel selected by the camp staff to order x-rays, routine tests, treatment, and necessary transportation for the above named individual. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp staff to secure and administer treatment, including hospitalization, for the individual as named above.

E. I attest to the fact that the above named individual is free of any communicable disease prior to attending camp.

F. I, as an individual, parent, guardian, or appointed representative of the individual, hereby grant AMI permission to use any narratives, film, photographs, videotape, sound, and digital recording of any kind made by AMI of the aforementioned individual for the promotion of its programs and services in any publication or media outlet including website entries, without payment or any other consideration. I understand and agree that these materials will become the sole and exclusive property of AMI. I irrevocably authorize AMI and its agents to edit, alter, copy, exhibit, publish, distribute, or otherwise use any of aforementioned individual's likeness derived above for the purposes of publicizing Arrowhead's programs or for any other lawful purpose. In addition, I waive the right to inspect or approve the finished product including written or electronic copy, wherein the individual's likeness appears. Additionally, I waive my right to royalties or other compensation arising or related to the use of any likeness. I hereby hold harmless and release and forever discharge AMI from all claims, demands, and causes of action which I, the aforementioned individual, heirs, representatives, executors, administrators, or any other persons acting on the individual's behalf or on the behalf of the individual's estate have or may have by reason of authorization.

Signature: _____

Please print name: _____

Date: _____

After review of the preceding information, the camp program manager will make a decision regarding acceptance into the camp program. **All necessary paperwork must be completed, signed, and submitted by May 23rd.** If the camper is accepted, you will receive a confirmation letter, medicine administration form, and list of what to bring to camp. The primary care provider will be contacted if the camp program manager has any concerns regarding acceptance. The registration fee will be refunded if the camper is denied acceptance to the program.