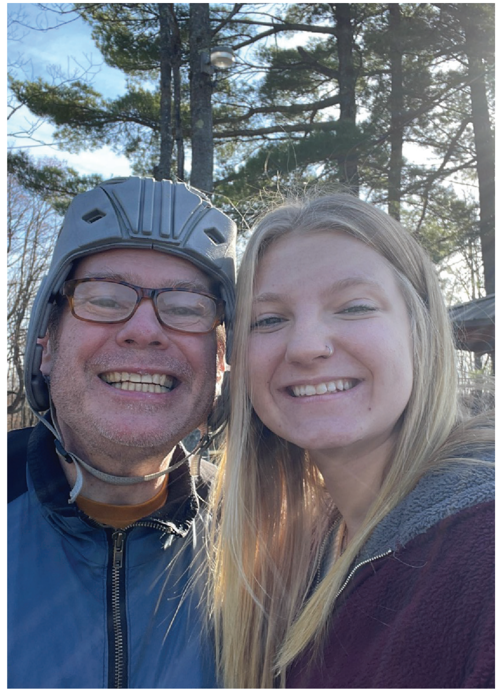
Shepherds Camp

serving adults with developmental disabilities

1 WEEK, 2 WEEK & 1:1 SESSIONS

MORE WEEKS | **MORE FUN** | **FALL 2023**



Shepherds Camp FALL 2023

We have even more weeks! Join us for special guests, seasonal activities & extra fun surprises!

3 WAYS TO SIGN UP

- Download from our website.
- Stop by the camp office.
- Call to request forms by mail or fax.

SAVE YOUR SPACE

1 - Completed Registration Form.
2 - Physical Form (within 1 year of camp date).
3 - $100 Deposit.

Did your camper attend a 2023 spring or summer session? If so, we only need the 1st page of the fall registration form

www.shepherdscamp.org | 570.663.2419 | pro.arrowhead@gmail.com

serving adults with developmental disabilities

FALL 2023 - Shepherds Camp
Registration Form

Registration form, physical within 1 year of camp date, and $100 deposit are required to reserve a space.

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: ☐ 2023 ☐ ______

If camper attended Spring or Summer 2023 and information has not changed – Only page 1 of this form is required.

Care Provider ____
Home Phone ( ) ______-________ Cell Phone ( ) ______-________
Address _____________________________ City ________________ State ____ Zip__________
Care Provider E-mail address _________________________________

Please Check Session(s) Desired:

Sessions – 1:5 Care

Cost: 1 Week Session - $625 | 2 Week Session - $1,250

Camper Check In: 10:00am | Camper Check Out: 1:00pm

☐ Wednesday, September 13th – Friday, September 22nd ***[2 week session]***

☐ Wednesday, September 27th – Friday, October 6th ***[2 week session]***

☐ Monday, October 16th – Friday, October 20th

☐ Wednesday, October 25th – Sunday, October 29th

☐ Wednesday, November 1st – Friday, November 10th ***[2 week session]***

☐ Monday, November 27th – Friday, December 1st

☐ Monday, December 4th – Friday, December 8th

☐ Monday, December 11th – Friday, December 15th

PLEASE INDICATE A 1ST & 2ND CHOICE FOR FALL SESSIONS.

1:1 Sessions **[Open to campers who require individual care]**

Cost: 1 Week Session - $1,450

Please select the week/weeks desired above.

☐ My camper requires 1:1 care.

Registration Fee: $100.00 (non-refundable) **Remaining Balance Due 1 month before selected camp session**

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

Make check or money order payable to: Arrowhead Bible Camp
Mail to: Arrowhead Bible Camp, 122 Arrowhead Cottage Rd., Brackney, PA 18812
Questions? Call - (570) 663-2419 Fax- (570) 663-2903 bkarrowhead@gmail.com www.shepherdscamp.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	☐	☐	☐	______________________
Showering	☐	☐	☐	______________________
Brushing Teeth	☐	☐	☐	______________________
Shaving	☐	☐	☐	______________________
Using Toilet	☐	☐	☐	______________________
Washing Hands and Face	☐	☐	☐	______________________
Tying Shoes	☐	☐	☐	______________________
Menstruation (women only)	☐	☐	☐	______________________

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: ________________________________

□ Whole Diet □ 1" Pieces □ ½" Pieces □ ¼" Pieces □ Ground □ Puree □ Meat Cut *Only*

Liquids: □ Thin □ Nectar □ Honey □ Pudding

□ 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): ___________________________

Food Restrictions: ____

Other:

(REQUIRED) OPWDD Food Modifications:

YES / **NO** (circle one) Camper is an OPWDD Individual and their diet must conform to the OPWDD Food Regulations.

If Yes, Describe: ____

____

If Yes, Eating Strategies: ____

____

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

□ Enjoys Water □ Fears Water

□ Swims Independently □ No Swimming

□ Needs 1:1 Supervision in Water

□ 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	□ Yes	□ No	Basketball	□ Yes	□ No
Volleyball	□ Yes	□ No	Nature Walks	□ Yes	□ No
Kickball	□ Yes	□ No	Fishing	□ Yes	□ No
Hay Ride (No Hay)	□ Yes	□ No	Bowling	□ Yes	□ No
Mini Golf	□ Yes	□ No	Bocce Ball	□ Yes	□ No
Pedal Carts	□ Yes	□ No	9 Square	□ Yes	□ No

Other:

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

<u>Emergency Contact Person</u> - 24-hour coverage - Person *<u>other than</u>* 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, and the PCP 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, or I have spoken with the Camp Nurse and Program Manager to ensure safety.

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 two weeks before camp session.** 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.

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2023 MEDICAL INFORMATION
CARE PROVIDER'S FORM

Camper ______________________________________ Age ______ ☐ M ☐ F DOB ___/___/___
Phone ( ) ______- ________

Parent/ Guardian / Care Provider Name(s)____
Insurance ______________________________________ Policy # __________________________

Your Medicare/Medicaid coverage or personal/family insurance would apply to all claims while at camp. However, the camp does provide Excess Medical Expense coverage.

Physician's Name _______________________________________ Phone ( ) ______- ________
Preferred Hospital for Emergency Treatment _______________________________________

Medical History (Diagnosis List):

____
____

Diabetes: ☐ ***Yes****, camper has Diabetes Mellitus* ☐ ***No****, camper does not have Diabetes Mellitus*
If Yes: Frequency of Glucose Checks ______ ☐ Insulin Shots ☐ Diet Management ☐ Medication Management

Communicable Diseases: ☐Hep A ☐ Hep B ☐ Hep C ☐HIV ☐ Not Applicable | Explain: ____________________

COVID-19 History:
☐ **Yes**, camper has had COVID-19, if yes when: ___________________ ☐ **No**, camper has not had COVID-19
☐ **Yes**, camper has been vaccinated for COVID-19 **Please provide a copy of proof of vaccination.**

Symptoms: Please check which problem areas experienced frequently by the camper and how you treat these at home. (Example: Diarrhea give Pepto Bismol)

Symptom	Remedies
☐ Nausea	__________________
☐ Diarrhea	__________________
☐ Stomach-aches	__________________
☐ Headaches	__________________
☐ Constipation	__________________

Allergies

☐ No Known Allergies
☐ Known Allergies: ________________________
____
____
____
____

Medication:
☐ Yes, the camper is regularly on medication. **Please contact your camper's doctor regarding any meds, ointments, etc. that could be put on hold while at camp**. A medication administration form will be sent with the confirmation letter which must be completed and submitted to camp in advance of your camp session.

Seizures: ☐ ***Yes****, camper experiences seizures (****see below****)* ☐ ***No****, camper does not experience seizures*
Please inform us on the following:

- Date of last seizure ___________
- Frequency of seizures _________ / week *or* _______/month
- Call 9-1-1 after seizures lasting _______ minutes
- Seizure presentation (what does a typical seizure look like) _________________________________

____

____ ______________
Care Provider's Signature **Date**

Mail to: Arrowhead Bible Camp, 122 Arrowhead Cottage Rd., Brackney, PA 18812
Please call Arrowhead Bible Camp with any questions (570) 663-2419 | Fax: (570) 663-2903

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2023 MEDICAL INFORMATION
ATTENDING PHYSICAN'S FORM

Camper's Name ______________________________
Physician's Name ____________________________ Phone (   ) _____- __________
Address __________________________________ State ______ Zip _______________
Hospital associated with: ____

A current **(within 1 year of camp date)** health physical *may* be attached. *Reverse side **must** be completed by Care Provider.

General Physical Condition

Height _______ Weight _______ BP ________ Eyes _______ Ears _______ Lungs _______

☐ Hypertension ☐ Hypotension ☐ Tachycardia ☐ Bradycardia ☐ Constipation

Date of last Tetanus shot _______ Is this camper subject to seizures? ☐ No ☐ Yes

Should the camper be restricted from any camp activities? ☐ No ☐ Yes,________________
____

Medication

Indicate the following:
☐ No prescription medication
☐ Independent / Self-Medicating
☐ Total support in receiving medication

Mental Evaluation

Diagnosis: ____
____

Further Comments: ____
____
____
____

________________________________ ____________
Physician's Signature **Date**