Shepherds Camp
Summer 2020

1 WEEK, 2 WEEK & 1:1 SESSIONS

Serving individuals with developmental disabilities since 1962.

SHEPHERDS CAMP AT ARROWHEAD
122 Arrowhead Cottage Road, Brackney PA
www.shepherdscamp.org  |  570.663.2419
Dear Staff & Family of Campers,

What a great year it’s been! I loved working through the Shepherds Camp Hall of Fame with you last summer and learning what it means to have faith in God. Since then we’ve been running full steam ahead with our Fall/Winter/Spring sessions of camp! It’s been a blast painting pumpkins, making Thanksgiving decorations, and going on walks in the snow with everyone; it’s hard to believe it’s already almost summer. I’m looking forward to hayrides, swimming, and playing kick-ball with you all!

Registration for Shepherds Camp Summer 2020 is now open; please take a minute to read the information below as you complete your registration:

SCHOLARSHIPS: We are excited to offer scholarships to our campers and invite you to apply as needed. Please contact us to request an application.

SECURING YOUR SESSION: In order to secure your spot we need the following 3 things: a completed registration form, a $100 deposit, and a copy of an updated physical (or date of the scheduled physical).

IDENTIFYING CAMPER CLOTHING: Please remember to write your camper’s full name or initials on the tag of each clothing item! We want to ensure that all camper clothing is sent home at checkout.

Our staff is already looking forward to this summer. We can’t wait to continue to provide the unforgettable experience of camp! See you all soon!

Sincerely,

Jack Lightbody
Program Manager

CAN’T WAIT UNTIL SUMMER?

Come join us in the spring! We still have a few spots remaining for our 3 weeks in March, we would love to have you with us as the snow melts away!
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: □ 2019 □ ______
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:

<table>
<thead>
<tr>
<th>1 Week Programs</th>
<th>$575 / person (Check out 10AM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Sunday May 31st- Friday June 5th</td>
<td></td>
</tr>
<tr>
<td>□ Sunday June 7th- Friday June 12th</td>
<td></td>
</tr>
</tbody>
</table>

Registration Fee: $100.00 (non-refundable) Remaining Balance: $475.00 Due May 23rd

<table>
<thead>
<tr>
<th>2 Week Programs</th>
<th>$1,150 / person (Check out 10AM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Sunday May 31st- Friday June 12th</td>
<td></td>
</tr>
<tr>
<td>□ Sunday June 21st - Friday July 3rd</td>
<td></td>
</tr>
<tr>
<td>□ Sunday July 26th - Friday August 7th</td>
<td></td>
</tr>
</tbody>
</table>

Registration Fee: $100.00 (non-refundable) Remaining Balance: $1,050.00 Due May 23rd

<table>
<thead>
<tr>
<th>1 to 1 Week Programs</th>
<th>$1,150 / person</th>
</tr>
</thead>
<tbody>
<tr>
<td>[open to campers who require individual care]</td>
<td></td>
</tr>
<tr>
<td>□ Monday May 25th, Check in @ 10:30 AM - Friday May 29th, Check out @ 1:00 PM</td>
<td></td>
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<tr>
<td>□ Monday June 15th, Check in @ 10:30 AM - Friday June 19th, Check out @ 1:00 PM</td>
<td></td>
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<tr>
<td>□ Monday July 13th, Check in @ 10:30 AM – Friday July 17th, Check out @ 1:00 PM</td>
<td></td>
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<tr>
<td>□ Monday July 20th, Check in @ 10:30 AM - Friday July 24th, Check out @ 1:00 PM</td>
<td></td>
</tr>
<tr>
<td>□ Monday August 10th, Check in @ 10:30 AM - Friday Aug 14th, Check out @ 1:00 PM</td>
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</tbody>
</table>

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.shepherdscamp.org
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:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent</th>
<th>Assistance</th>
<th>Total Care</th>
<th>Please specify assistance required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Showering</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Brushing Teeth</td>
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<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Shaving</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Using Toilet</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Washing Hands and Face</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Tying Shoes</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Menstruation (women only)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
</tbody>
</table>

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:

YES / NO (REQUIRED - CIRCLE ONE) OPWDD Food Modifications:
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.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Archery</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Volleyball</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Kickball</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Hay Ride (No Hay)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Mini Golf</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Pedal Carts</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Basketball</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Nature Walks</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Fishing</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Bowling</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Bocce Ball</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>9 Square</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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

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 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.
Camper ___________________________ Age _____ □ M □ F DOB ___/___/___
Phone (_____) ______-_________

Parent/ Guardian / Care Provider Name(s) ___________________________ 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: _______________________

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

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Remedies</th>
<th>Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Nausea</td>
<td>_____________________________</td>
<td>□ No Known Allergies</td>
</tr>
<tr>
<td>□ Diarrhea</td>
<td>_____________________________</td>
<td>□ Known Allergies:_____________</td>
</tr>
<tr>
<td>□ Stomach-aches</td>
<td>_____________________________</td>
<td></td>
</tr>
<tr>
<td>□ Headaches</td>
<td>_____________________________</td>
<td></td>
</tr>
<tr>
<td>□ Constipation</td>
<td>_____________________________</td>
<td></td>
</tr>
</tbody>
</table>

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: Shepherds Camp, 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
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 ☐ Total support in receiving medication
☐ Independent / Self-Medicating

Mental Evaluation
Diagnosis: ________________________________________________________________

Further Comments: ________________________________________________________

_________________________________              __________
Physician’s Signature                        Date
Consent for Non-Prescription Medications
2020 - for use during camp stay only

Camper Name: _________________________

These commonly used PRN medications are stocked at camp. Please mark Y for each medication that the camper may receive while at camp and N for medication the camper may not receive while at camp. The camp nurse dispenses all medication and records it on the camper’s camp medication sheet. Please submit this form by May 23rd, 2020.

*ALL CAMPERS NEED A Consent for Non-Prescription Medications SUBMITTED TO ATTEND SHEPHERDS CAMP*

- Tylenol (acetaminophen): 2 tablets (325 mg) by mouth for headache or temperature of 101°F or over, or for c/o minor pain, every 4 hours as needed (PRN). Maximum Daily Dose (MDD) 12 tabs per day. Not to exceed 2 days.

- Ibuprofen: 1 tablet (200mg) by mouth every 4 hours for muscle aches. Not to give simultaneously with other analgesics (i.e.: Tylenol or Aspirin). Not to exceed 2 days. Maximum Daily Dose 6 tabs.

- Bacitracin Ointment: Apply a small amount to affected area for minor skin abrasions to open sores BID as needed. Not to exceed 2 days. Maximum Daily Dose 2 times per day.

- Calamine Lotions: Moisten cotton or soft sloth with lotion to apply to affected areas to alleviate itching, to rash area, or bug bites TID as needed. Not to exceed 2 days. Maximum Daily Dose 3 times per day.

- Robitussin: Administer 2 tsp. every 4 hours as needed for cough. Not to exceed 2 days. Maximum Daily Dose 12 tsp. per day.

- Maalox/Mylanta: Administer 2 tsp. by mouth as needed between meals, at HS for indigestion. Not to exceed 2 days. Maximum Daily Dose 4-8 tsp. per day.

- Pepto-Bismol (bismuth subsalicylate): 2 Tbsp. by mouth every .5 to 1 hour as needed for upset stomach and/or diarrhea. Not to exceed 8 doses in 24 hours, or use until diarrhea stops but not more than 2 days.

- Cough drops: for throat irritation/sore throat. 1 drop every 2 hours not to exceed 6 per day over 2 days.

- Benadryl (Diphenhydramine HCl): 2 tablets (50mg) every 4 to 6 hours for runny nose, sneezing, itchy, watery eyes, itching nose or throat. Not to exceed 6 doses in 24 hours. Not to exceed 2 days.

- Milk of Magnesium: for constipation (no bowel movement after 3 days) take 2-4 Tbsp. followed by a large glass of water. If no bowel movement within 24 hours, camp nurse will notify camper emergency contact.

- Imodium: Administer 2 caplets for advanced anti-diarrheal & anti-gas. No more than 4 caplets in 24 hours. Only used in severe cases of diarrhea.

- 1% Hydrocortisone: for itching of skin, irritation, inflammation, and rashes, apply a small amount to affected area not more than 3 to 4 times daily.

- TUMS: Relief of upset stomach due to heartburn, acid indigestion, or sour stomach. 1000 to 2000 mg by mouth up to 3 times a day as needed, not to exceed 7500 mg/day.

Parent/Care Provider Signature: ____________________________ Date: ____________

Physician Signature (if required*): ____________________________

*only required if required by your agency/home/department