



## 2020 CAMPER APPLICATION

A \$50.00 application fee is required with each application.  
Make check payable to: Camp CaPella

*If we are unable to accommodate your request, half of the application fee received will be returned.*

Please read carefully.

Incomplete applications will not be processed.

Please do not omit information.

### **Important Information:**

**ALL APPLICATIONS MUST BE RECEIVED BY MARCH 13, 2020**

- Applications are reviewed carefully and information requested is used by staff to determine if Camp CaPella is a good fit for your camper.
- Space is limited and many factors are taken into consideration.
- Campers are accepted and placed in what we believe will offer them the best camp experience possible.
- If you have any questions and/or concerns, please do not hesitate to reach out.

*Applications received AFTER March 13th, will be processed on a first come basis, as space is available.*

### **Return completed application to:**

Camp CaPella  
Heidi Riggs, Camp Director  
PO Box 552, Holden, ME 04429  
Fax: 207-843-7413  
Email: [heidi@campcapella.org](mailto:heidi@campcapella.org)

For Questions:  
Call Camp at 207-843-5104  
Heidi Cell at 207-479-0442 or  
Email [heidi@campcapella.org](mailto:heidi@campcapella.org)

## Camper Eligibility Policy

Please read carefully. In order to attend Camp CaPella, all campers must be able to meet the following requirements. Contact us if you have questions about your camper's eligibility.

### **The camper:**

- Must have a primary diagnosis of an intellectual and/or physical disability, and is otherwise unable to attend a traditional summer camp program.
- Day campers start at age 5. Overnight campers start at age 8. There will be separate weekly sessions for campers based on age.
- Must be able to interact with others, individually or with assistance, and participate in the camp program.
- **Must be free of physically aggressive behaviors.**
- Must be able to adapt to staff supervision ratio of one staff to three campers. We are prepared to provide 1:1 care when needed for personal care, such as feeding, toileting, bathing, etc. *We do not have the resources to serve campers who require constant 1:1 supervision and/or care throughout their stay at camp.*
- **We cannot accept campers with emotional disturbance disorders.**
- Applicants who will be accompanied by a medical caregiver because of their specific medical needs will be considered on an individual basis.

I agree that \_\_\_\_\_ meets the above requirements to attend  
Camp CaPella.  
(Camper Name)

---

Print Name

Relationship to Camper

---

Signature

Date

**Camper Information** (print clearly)

Name: \_\_\_\_\_

Diagnosis : \_\_\_\_\_

Age: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Address: \_\_\_\_\_

Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Email: \_\_\_\_\_

School or Program Attended: \_\_\_\_\_

Does camper require 1:1 support in school and/or program setting? YES NO

Emergency Contact: \_\_\_\_\_

Case Manager Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Case Manager Email: \_\_\_\_\_

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

I give permission for Camp CaPella to speak with case manager if needed.

\_\_\_\_\_  
Signature Date

**Parent/Guardian Information**

Name: \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

Address: \_\_\_\_\_

Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Work Phone: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Method of Contact: \_\_\_\_\_

Best Time To Contact: \_\_\_\_\_

**Parent/Guardian Information**

Name: \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

Address: \_\_\_\_\_

Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Work Phone: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Method of Contact: \_\_\_\_\_

Best Time To Contact: \_\_\_\_\_

If parent/guardian cannot be reached, who can we contact, in order of preference:

Name	Relationship	Phone Number(s)
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Name	Relationship	Phone Number(s)
------	--------------	-----------------

Name	Relationship	Phone Number(s)
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While at camp, parent/guardian will be:

\_\_\_\_\_ At home

\_\_\_\_\_ On vacation and may be reached at \_\_\_\_\_ dates \_\_\_\_\_

Persons camper can be released to:

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

Persons camper MAY NOT be released to:

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

**Please Note:** As you complete the camper application, please keep in mind that Camp CaPella is an accessible recreational opportunity in which campers participate in a wide variety of activities that may include swimming, boating, recreational games, music, arts-n-crafts, as well as, daily special events. During these activities we will provide a 1:3 staff to camper ratio.

*If camper requires 1:1 supervision in order to participate, for safety or behavior, you **must** provide an individual support person to attend with your camper.*

Please carefully consider all questions and do not omit information. Incomplete applications will not be processed.

Feel free to use additional paper if you need more space .

**PLEASE CHECK THE FOLLOWING STATEMENT AS IT APPLIES TO YOUR CAMPER**

\_\_\_\_\_ I feel comfortable this camper will participate in camp activities in a safe and appropriate manner , and will be adequately cared for by our 1:3 staff to camper ratio.

\_\_\_\_\_ I feel, at certain times, a 1:3 ratio will not be adequate supervision. Please list reasons for additional assistance below.

\_\_\_\_\_ I feel this camper is always in need of 1:1 supervision. An individual support person will accompany this camper. Please complete additional information below.

My camper will need additional assistance at times for: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

An individual support person will attend with my camper.                      YES    NO

Name of support person:

\_\_\_\_\_

Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

## Health, Behavior, Skills and More

To be completed by primary caregiver and submitted with application. Please print clearly.

Camper name: \_\_\_\_\_

Disability/Diagnosis: \_\_\_\_\_

Mobility: please check all that apply

Ambulatory                       Uses Wheelchair                       Transfer Assistance  
 Ambulatory with assistance                       Manual chair                       Independent  
      Staff assistance                       Can propel self? Y N                       1 person pivot  
      Cane/Walker                       Power chair                       2 person pivot  
      AFO (Type: \_\_\_\_\_)                       Hoyer Lift

### Activities of Daily Living/Personal Care (please check all that apply)

	Independent	Verbal Prompts	Hand Over Hand	Total Assist	Describe Assistance Needed
<b>Dressing</b>					
Tie shoes	_____	_____	_____	_____	_____
Button/Zipper	_____	_____	_____	_____	_____
<b>Showering</b>					
Shampoos hair	_____	_____	_____	_____	_____
Wash with asst	_____	_____	_____	_____	_____
<b>Teeth</b>					
_____	_____	_____	_____	_____	_____
<b>Toileting</b>	Independent, no concerns	Reminders to use bathroom	Assistance with wiping		
Aids used (circle one)	Depends When?	Bedpan/Urinal (you bring)	Toilet chair	Other:	_____
Bladder control (circle one)	Continent	Occasional accidents	Incontinent	Catheter & Type:	_____
Bowel control (circle one)	Continent	Occasional accidents	Incontinent	Bowel Program	_____
<b>Eating</b>					
	Independent, no Concerns	Needs prompts to eat	Needs to be fed		
Utensils	Conventional utensils	Adaptive utensils (you bring)	Finger foods only		
Dietary Needs	Cut into bite size pieces	Mechanically chopped diet only	Pureed diet only		
	Gluten Free	Dairy Free	G-Tube	Other:	_____

For those campers on a gluten/dairy free or other restrictive diet, we will accommodate as best we can; however, please feel free to bring supplemental foods to last throughout the week.

Other dietary restrictions: \_\_\_\_\_  
\_\_\_\_\_

Food allergies: *(please list along with reaction)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Communication Skills** (please check all that apply)

*Expressive Communication:*

- Verbal, can be clearly understood
- Verbal, is difficult to understand
- Non-verbal
- Limited verbal vocab
- Uses gestures
- Uses Sign Language
- Uses communication device  
\_\_\_\_\_

*Receptive Communication:*

- Can easily understand & follow directions
- Understands sign language
- Needs time to process & act on instructions
- Needs reminders & cues
- Cannot process/does not follow directions
- Other means of communication:  
\_\_\_\_\_

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have there been any life changes you would like to share with us that may be helpful to ensure a successful camp session?** (i.e. new home, new school, marriage, divorce, death, health changes, etc.)

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

**Behavioral Information** (please check all that apply)

\_\_\_ Has a behavior support plan (*please attach a copy*)

History of:

\_\_\_ Verbal aggression

\_\_\_ Physical aggression toward others

\_\_\_ Biting

\_\_\_ Hitting

\_\_\_ Kicking

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

\_\_\_ Wandering/Running away from group

\_\_\_ Self-injurious behaviors

\_\_\_ Picking/Scratching

\_\_\_ Head banging

\_\_\_ PICA (please explain) \_\_\_\_\_

\_\_\_ Biting

\_\_\_ Other behaviors to be noted: \_\_\_\_\_

\_\_\_ No behavioral issues

Please list any behaviors we may see at camp: \_\_\_\_\_

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

How often do behaviors occur? \_\_\_\_\_

\_\_\_\_\_

What causes the behavior? (triggers): \_\_\_\_\_

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

Recommended redirection techniques: \_\_\_\_\_

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

*Reminder: If camper requires 1:1 supervision in order to participate, for safety or behavior, you **must** provide an individual support person to attend with your camper.*



**Night Time Routine** (please check all that apply)

*(Please note: A minimum of two counselors sleep in the bunkhouse with campers. There is no awake overnight staff.)*

No concerns, sleeps through the night

Wakes to toilet independently

Wakes to toilet with assistance

Wanders at night

Wakes early; please note time: \_\_\_\_\_

Requires medication to help sleep

Requires bedrails

Requires adjustment/repositioning at night, please describe: \_\_\_\_\_  
\_\_\_\_\_

Additional comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Adjustment to Camp** (please circle one)

Has your child been to a summer camp (other than Camp CaPella) before? YES NO

If so, did he/she adjust well? YES NO

Has your child ever been away from home before? YES NO

Do you think he/she is likely to be homesick? YES NO

If you think homesickness will be an issue, please give us some suggestions on how to best help your camper adjust. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Favorite camp activities \_\_\_\_\_  
\_\_\_\_\_

Least favorite camp activities: \_\_\_\_\_  
\_\_\_\_\_

Swimming Level: please check one

Non-swimmer/does not like water

Beginner

Intermediate

Advanced

Swimming comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **2020 Summer Camp Schedule**

Overnight Camp will run weekly from **Sunday** afternoon to **Friday**.

Day Camp will run weekly from **Monday** to **Friday**, 8:30am to 4:30pm.

*Please circle your choice and indicate your 1st and 2nd choice weeks, if applicable.*

<b>AGE GROUP</b>	<b>OVERNIGHT CAMP</b>	<b>DAY CAMP</b>	<b>WEEK</b>
Adults*	June 24 to June 26*	June 24 to June 26*	1*
Adults	June 28 to July 3	June 29 to July 3	2
5-10 yo	July 5 to July 10	July 6 to July 10	3
10 - 12 yo	July 12 to July 17	July 13 to July 17	4
12-15 yo	July 19 to July 24	July 20 to July 24	5
15 - 18 yo	July 26 to July 31	July 27 to July 31	6
18-25 yo	Aug 2 to Aug 7	Aug 3 to Aug 7	7
Adults	Aug 9 to Aug 14	Aug 10 to Aug 14	8

***\*June 24 to June 26 is a special 3 day, camp option for adult campers who may benefit from a shorter camp experience.***

Overnight camp space is very limited. If full, would day camp be an option? YES NO

Did you attend Camp CaPella in 2019? YES NO DAY OVERNIGHT

Did you attend Camp CaPella prior to 2019? YES NO If yes, when? \_\_\_\_\_

## **Travel Camp**

Travel camp opportunities may include day trips, as well as, overnight retreats. Travel camp opportunities will be available in the Spring, Fall and Winter months. Previous travel camp options have included a Columbus Day Weekend Retreat to the Adaptive Outdoor Education Center, Winter Fun in Greenville, and more.

Would your camper be interested in Travel Camp options? YES NO

## **Camp Fees**

The cost to attend one week of camp is \$1500.00. It is our policy to never turn away a camper based on ability to pay. We do ask all of our campers to contribute a co-pay of \$300. We understand that this may not be feasible for some of our campers and their families and any contribution you can afford will be greatly appreciated.

We are more than happy to make payment arrangements and offer suggestions to help you raise your camp fees.

Please let us know how much you anticipate to pay towards camp fees. Please check your answer.

I can pay the full price of \$1500 \_\_\_\_\_ \$1500 with payment arrangements \_\_\_\_\_

I can pay half at \$750 \_\_\_\_\_ \$750 with payment arrangements \_\_\_\_\_

I can pay the \$300 co-pay \_\_\_\_\_ \$300 co-pay w/ payment arrangements \_\_\_\_\_

I can pay a portion of my camp fees \_\_\_\_\_ Indicate how much you hope to pay \_\_\_\_\_

I will need to make payment arrangements \_\_\_\_\_

Additional comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Permission Forms:**

**Photo Release:** Do you give Camp CaPella permission to video tape or photograph this camper while attending camp for 2019 for future promotional purposes? YES NO  
Please Note: Photos taken are for Camp CaPella Use Only

**Field Trip Release:** Do you give permission for your camper to leave camp grounds for the purpose of a camp related field trip? YES NO

**Transportation Release:** Do you give permission for Camp CaPella staff to transport your camper for field trips, travel camp or emergency purposes? YES NO

**Medical Release:** In the case of emergency, I understand every effort will be made to contact me/the listed contact person. In the event I cannot be reached, I give permission to Camp CaPella to secure proper treatment, including hospitalization, necessary tests, anesthesia, surgery or injections of medication for me/this participant. Permission is given to transport me/this participant for medical assistance as deemed necessary by Camp CaPella staff. I understand I am responsible for payment of all medical treatments. The medical forms within this application may be photocopied for camp use. YES NO

**Immunizations:** Are there any immunization exemptions due to religious, medical or other reasons? YES NO

If yes, please explain: \_\_\_\_\_

\*I understand and accept the risks of my camper not being fully immunized. I understand if there is an outbreak, I will be required to pick up my camper from the camp program.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

I have reviewed this completed application. All information provided is correct to the best of my knowledge, and the participant herein described has permission to engage in all activities except as noted.

By signing below, I understand the guidelines as outlined within this application, and agree to follow them.

\_\_\_\_\_  
Signature of Camper/Parent/Guardian

\_\_\_\_\_  
Date

# Camp T-Shirt Order Form

## It's time to order your 2020 Camp CaPella T-Shirts!

Camp CaPella will provide 1 complimentary t-shirt for each camper.  
Please complete this form so your camper's shirt will be available when they arrive at camp.

If you would like to order additional shirts,  
please return this form with \$20.00 payment per additional shirt.

**Camper Name:** \_\_\_\_\_

**Size Needed:** *(please check one)*

**Child:**    \_\_\_\_\_ Small                      \_\_\_\_\_ Medium                      \_\_\_\_\_ Large  
**Adult:**    \_\_\_\_\_ Small                      \_\_\_\_\_ Medium                      \_\_\_\_\_ Large  
                  \_\_\_\_\_ XL                      \_\_\_\_\_ XXL                      \_\_\_\_\_ Other *(please specify)*

**Order:**

<b><u>Item</u></b>	<b><u>Quantity</u></b>	<b><u>Cost</u></b>	<b><u>Total Due</u></b>
Additional T-Shirt(s)	_____	X \$20.00 each	= \$ _____

Please indicate sizes above

Hang in there, you are almost finished!





The following four pages are required medical forms.

They **MUST** be completed by your physician.

Acceptance to camp cannot be determined until medical forms have  
been returned to camp.







Return medical forms to:  
Mail: Camp CaPella, PO Box 552, Holden, ME 04429-0552  
Fax: 1-207-843-7413  
Email: heidi@campcapella.org  
Phone: 1-207-843-5104 with any questions and/or concerns

**Medical Information**

**The following 4 pages MUST be completed and signed by a physician.  
Acceptance to camp cannot be determined until all medical forms are returned.**

Camper Name: \_\_\_\_\_

Disability: \_\_\_\_\_

DOB: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Allergies** (please list allergy and reaction)

Medication Allergies: \_\_\_\_\_

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

Food Allergies: \_\_\_\_\_

\_\_\_\_\_

Other Allergies: (hay fever, animals, insect bites or stings, etc.) \_\_\_\_\_

\_\_\_\_\_

**Seizures**

Is this camper subject to seizures? YES NO If yes, please attach any special protocol.

Seizure Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

Seizure Triggers: \_\_\_\_\_

How long do seizures last? \_\_\_\_\_ Date of most recent: \_\_\_\_\_

Notify parent/guardian: \_\_\_ after every seizure \_\_\_ after seizure lasting \_\_\_ mins \_\_\_ no notice

**Health History** (Please check all that apply)

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Mononucleosis           | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Poison Ivy  |
| <input type="checkbox"/> Measles              | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Asthma      |
| <input type="checkbox"/> Hay Fever            | <input type="checkbox"/> Insect Stings           | <input type="checkbox"/> Mumps       |
| <input type="checkbox"/> Hospitalization      | <input type="checkbox"/> Lyme Disease            | <input type="checkbox"/> Other       |

Explain other: \_\_\_\_\_

Medical conditions requiring notification of guardian and physician: \_\_\_\_\_

\_\_\_\_\_

Operations or serious injuries or mental health concerns: \_\_\_\_\_

\_\_\_\_\_

**Specialized Health Care Procedures**

Does the camper require a specialized health care procedure while attending camp (i.e. nebulizer treatments, catheterization, etc.): YES NO If yes, please complete the following:

Name of Procedure: \_\_\_\_\_

Description of Procedure: Please include time intervals and conditions or symptoms that warrant repeating the procedure \_\_\_\_\_

\_\_\_\_\_

List any precautions staff must be aware of before, during or after the procedure: \_\_\_\_\_

\_\_\_\_\_

**Mental Health Information**

Is there a history of mental health issues? YES NO

Have there been any recent issues? YES NO If yes, date of occurrence: \_\_\_\_\_

Has there been any hospitalization, or stay at a mental health facility, due to mental health issues? YES NO If yes, date of occurrence: \_\_\_\_\_

If yes to any of the above, please explain more. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Female Camper Information**

Has this camper menstruated? YES NO

If not, has she been informed? YES NO

If yes, does she require assistance? YES NO

Additional comments: \_\_\_\_\_

\_\_\_\_\_

**Immunizations** (you may attach immunization record in place of form)

	Year of Basic Immunization	Year of Last Booster
DTap	_____	_____
Tetanus	_____	_____
Polio (IPV)	_____	_____
MMR	_____	_____
Pneumococcal (PCV)	_____	_____
Haemophilus Influenza (HIB)	_____	_____
Hepatitis B	_____	_____
Varicella (Chicken Pox)	_____	_____
Meningitis	_____	_____
Other	_____	_____

Are there any immunization exemptions due to religious, medical or other reasons? Y N  
If yes, please explain: \_\_\_\_\_

\*I understand and accept the risks of my camper not being fully immunized. I understand if there is an outbreak, I will be required to pick up my camper from the camp program.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Medication**

***Please note - camper must be on a stable medication regime, and not in the process of changing medication or altering the dose of current medication, for at least one month prior to attending camp.***

\_\_\_ This camper takes no medications on a routine basis.

\_\_\_ This camper takes medications as listed below. Attach additional sheets if needed.

Name of Medication	Dosage	Time Given
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Assistive Devices**

Eyes: Does camper wear glasses? YES NO      If yes, color of frame? \_\_\_\_\_

Ears: Does camper wear hearing aids? YES NO      If yes, what support is needed? \_\_\_\_\_

Orthotics: Does camper wear AFO or other braces? YES NO

If yes, what support is needed? \_\_\_\_\_

Other assistive devices used: \_\_\_\_\_

\_\_\_\_\_

**Health Care Recommendations From Physician**

Blood Pressure \_\_\_\_\_      Weight \_\_\_\_\_      Height \_\_\_\_\_

In my opinion, this individual is capable of participating in camp activities except for the restrictions stated below.                      YES                      NO

Limitations or Restrictions:

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

Medical Concerns or Treatments to be monitored during camp: \_\_\_\_\_

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

Date of Most Recent Physical: \_\_\_\_\_

I certify that I have completed a physical of this person on the date listed above, which is within one year of the expected camp participation date. This person is in satisfactory condition to participate in an active summer camp program for and with people with disabilities. I am aware of all medications prescribed to this camper, as listed on the medication form, and see no contraindications.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Name and Title (Printed)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone



**Before you submit your application, have you:**

Read, understood and signed the camper eligibility form?

Completed ALL sections of the application?

Selected your preferred camp week?

Completed the t-shirt order form?

Medical forms are: (check one)

Included

At doctor's office

Will be sent by doctor

Included application fee?

Incomplete applications will not be processed until all required information is provided.  
Please do not omit information.